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Supreme Court of the United States

OCTOBER TERM, 1996

KIMBERLY BELSHÉ, Director of the State Department of Health Services, State of California,

Petitioner,

vs.

ORTHOPAEDIC HOSPITAL and the CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Plaintiffs Orthopaedic Hospital (an acute care hospital) and the California Association of Hospitals and Health Systems (a hospital trade group), (hereinafter "the Hospitals"), brought suit against defendant Kimberly Belshé, Director of the State Department of Health Services (hereinafter "the Department") based upon the Hospitals' dissatisfaction with the reimbursement rates that the Department pays to hospitals which provide outpatient services, in a hospital setting, to beneficiaries of the state's medical assistance program (hereinafter "Medicaid" or "Medi-Cal").

1. Does 42 U.S.C. § 1396a(a)(30)(A) require that, in setting Medicaid reimbursement rates paid to health care providers who treat Medicaid beneficiaries, states must consider the costs which health care providers incur in delivering services; must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services; and that states must rely on studies of provider costs as a basis for their Medicaid rate setting?

2. Does 42 U.S.C. § 1396a(a)(30)(A) create a private right of action for health care providers under 42 U.S.C. § 1983?

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Kimberly Belshé, Director of the Department of Health Services of the State of California ("the Department"), respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The published opinion of the United States Court of Appeals for the Ninth Circuit, reversing the judgment of the district court, is reported as *Orthopaedic Hospital v. Belshé*, 103 F.3d 1491 (9th Cir. 1997). A copy of the opinion is reproduced in Appendix A of this Petition. The order of the Ninth Circuit, denying rehearing and rehearing *en banc*, is unreported and reproduced in Appendix C. The order of the United States District Court for the Central District of California (Wilson, D.J.) is unpublished and is reproduced in Appendix B of this Petition.

STATEMENT OF JURISDICTION

The opinion below was filed on January 9, 1997. The Ninth Circuit denied the Department's petition for rehearing and suggestion for rehearing *en banc* on March 27, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS

42 U.S.C. § 1396a provides, in pertinent part: "State plans for medical assistance

"(a) Contents. A State plan for medical assistance must--

* * *

> "(30)(A) provide for such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4) [42 U.S.C. § 1396b(i)(4)]) as may be necessary to safeguard against unnecessary utilization of care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . ."

42 U.S.C. § 1396a(a)(13) ("The Boren Amendment") provides in relevant part: "A State plan for medical assistance must . . . provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the state . . .) which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws. . ."

42 U.S.C. § 1983 provides that: "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

STATEMENT OF THE CASE

1. The "Orthopaedic I" Litigation

In August 1990 these same plaintiffs (Orthopaedic Hospital and the California Association of Hospitals and Health Systems ("CAHHS")) filed *Orthopaedic Hospital, et al. v. Kizer*, No. 90-4209 SVW (JRx) ("*Orthopaedic I*"). In *Orthopaedic I*, plaintiffs alleged that all outpatient reimbursement rates paid by California to hospitals which provide outpatient services to Medicaid, called Medi-Cal in California, beneficiaries violate state and federal law (including 42 U.S.C. §§ 1396a(a)(13)(A) and 1396a(a)(30)(A)--the Boren Amendment.)[1] The district court ruled that 42 U.S.C. § 1396a(a)(13)(A) is inapplicable to outpatient rates and governs only hospital outpatient, nursing homes and intermediate care for mentally retarded. The case was ultimately resolved by summary judgment, which was granted for the Hospitals in part and for the Department in part.

Based upon the district court's review of the administrative record lodged in *Orthopaedic I*, the court determined that the administrative record did not establish that the Department had adequately considered the factors of efficiency, economy, and quality of care in enacting certain particular outpatient rates, but that the Department had adequately considered these factors in enacting certain other outpatient rates. (*Orthopaedic I*, Second Revised Judgment at 2).

Despite the court's finding of procedural irregularities in the way in which certain of the hospital outpatient rates

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1. Set forth in Appendix D.

had been enacted, the court did not invalidate any of the challenged rates.[2] The court stated,

> "The Court has not made any ruling on the validity of the rates themselves and cannot comment on whether the defendant will be able to set similar or identical rates once it conducts a proper inquiry and considers 'efficiency, economy and . . . quality of care.'" (*Orthopaedic I*, Order Amending Rev. Judg., 2:20-24.)

In its order which became final on February 12, 1993, the court affirmed some rates, but directed the Department to take "appropriate corrective action" in regard to certain other specified Medi-Cal reimbursement rates paid to providers of outpatient services. It further ruled that "the improperly promulgated rates will remain effective until the Department sets new rates upon considering the relevant factors." (Second Revised Judgment, 2:9-13).

The court "remand[ed] the matter to defendants for further proceedings consistent with its opinion" (*Orthopaedic I*, Order Correcting Judgment, 2:7-8), and the Department then took immediate action to comply fully and expeditiously with the Court's rulings.

2. The Remand

Pursuant to the final judgment ordering a remand to the Department, in Spring and Summer 1993 the

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2. The district court stated that it "did not invalidate any of the challenged rates [in *Orthopaedic I*] . . ." (ER at 106:17-18.) "As a preliminary matter, the Court must dispose of one of plaintiffs' pervading themes. Plaintiffs argue that [pursuant to *Orthopaedic I*] . . . the Department should have . . . adopted new payment rates. . . . The Court rejects plaintiffs' contention." (ER at 117:16-22.)

Department conducted a lengthy review of outpatient rates. The Department's review culminated in September 1993 in a 53-page single-spaced rate study entitled Consideration of Efficiency, Economy, Quality of Care and Access With Respect to Changes in Medi-Cal Reimbursement for Hospital Outpatient Services. (The "Rate Study") 1 AR __. The Rate Study referenced over 700 pages of supporting material. 2 AR 1-738.

On December 16, 1993 the Department held a public hearing in Sacramento with regard to those rates. Public comments and voluminous materials were received from both CAHHS and the California Association of Public Hospitals. 3 AR 71-2159. The Department reviewed these materials in detail and at great length. Pursuant to the Administrative Procedures Act, the Department generated a summary document, entitled "Addendum to Report, Rate Study by the Department of Health Services." (The "Addendum") 3 AR 1-49. After analyzing the 2100 pages of public comment and response (3 AR 71-2159), the Department on April 15, 1994 determined that there was no legal or factual basis for alteration of the rates. The Department therefore readopted the reimbursement levels of hospital outpatient services as currently set forth in Medi-Cal regulations. 3 AR 1.

3. The District Court Proceedings

The Hospitals, unhappy with the result of the remand, returned to court by means of two virtually identical suits that were eventually consolidated by the district court. Plaintiffs originally filed Case No. 94-4825 (*Orthopaedic II*) in Los Angeles Superior Court on October 23, 1992, seeking retroactive relief following entry of the federal court's initial judgment in *Orthopaedic I*. On July 6, 1994, plaintiffs filed a First Amended

Complaint in state court in *Orthopaedic II*, broadening the proceeding to include prospective, as well as retroactive, relief. On July 15, 1995, plaintiffs filed Case No. 94-4764 in the district court ("*Orthopaedic III*"). The basis of federal jurisdiction in the first instance was 28 U.S.C. §§ 1331 and 1343. The Department then removed *Orthopaedic II* to federal court. The Hospitals filed opposition. The district court ruled that it would retain and adjudicate all claims for prospective, injunctive or declaratory relief in *Orthopaedic II*, remanding only the retroactive relief portion of *Orthopaedic II* to state court (Docket 19). The district court then consolidated the two cases (Docket 13). The Hospitals later dismissed their state court action without prejudice.

In March 1995, following extensive briefing and oral argument, the district court granted summary judgment for the Department in *Orthopaedic II* and *III*. (Appendix B.)

4. Ninth Circuit Proceedings

The Hospitals timely appealed the district court's decision granting summary judgment in favor of the Department. The decision in the trial court had been based upon the district court's review of an Administrative Record, upon which the Department based its rate-setting, consisting of ten volumes totaling nearly 3,000 pages.

In its published opinion, the Ninth Circuit reversed the district court's entry of summary judgment. The Ninth Circuit defined the issue as:

> "whether the statute requires the Department to consider the costs hospitals incur in delivering services when setting specific payment rates under 42 U.S.C. §1396a(a)(30)(A). . . ."(*Orthopaedic*, 103 F.3d at 1496).

The Ninth Circuit concluded that:

> "the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting." (Id. at 1496).

The Ninth Circuit rejected the Department's contention that the Hospitals' interpretation of 42 U.S.C. § 1396a(a)(30)(A) would contradict legislative intent and render superfluous 42 U.S.C. § 1396a(a)(13)(A) ("the Boren Amendment"). (Id. at 1498-1499).

The Ninth Circuit opinion requires the Department to:

> "undertake responsible cost studies that will provide reliable data as to the hospitals' costs in providing outpatient services to the end that it determine the cost to an efficient hospital economically providing quality care. The state must then set rates that have some reasonable relation to such costs, the state bearing the burden of justifying any rate that substantially deviates from such determined costs." (Id. at 1500).

The Department filed a timely petition for rehearing and rehearing *en banc*, asserting that the Ninth Circuit's ruling overlooked the longstanding federal interpretation of 42 U.S.C. § 1396a(a)(30)(A); the new payment standard set out in the opinion has no support in statutory or regulatory history and conflicts with the Seventh and

Eighth Circuits' reading of the same statute; that the new payment standard will create administrative chaos for the states because it is not a feasible standard for thousands of separate medical services, supplies, drugs, items, and equipment, and it will take many years and many additional state employees to set rates pursuant to such a payment standard (citing data collection problems and problems caused by the existence of many thousands of different outpatient services); and that the Ninth Circuit's decision is likely to result in an explosion of extremely complicated rate litigation in the federal courts. The Ninth Circuit denied the petition for rehearing and suggestion for rehearing *en banc*. (Appendix C.)

REASONS FOR GRANTING THE PETITION

This case involves a question of exceptional national importance, involving the interpretation of a critically important federal statute which governs all Medicaid rate-setting--42 U.S.C. § 1396a(a)(30)(A). The Ninth Circuit opinion dramatically departs from the statutory interpretation which the courts and the federal Medicaid agency have previously applied. It also conflicts with the Seventh and Eighth Circuits' reading of 42 U.S.C. § 1396a(a)(30)(A).

The opinion will have a tremendous impact on Medicaid rate setting, not only in California, but throughout the Ninth Circuit and across the nation. It could increase state and federal Medicaid expenditures by many billions of dollars annually. The administrative burden the ruling imposes on the states and the federal courts is equally staggering. The Ninth Circuit overlooked the longstanding federal interpretation of the statutes and wrested discretion in rate-setting from the states.[3]

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3. The Ninth Circuit also ignored a study in the Administrative

While states have traditionally been granted broad discretion in Medicaid rate-setting,[4] the Ninth Circuit has now ruled that 42 U.S.C. § 1396a(a)(30)(A) requires that, in setting Medicaid reimbursement rates paid to health care providers who treat Medicaid beneficiaries, states must now consider the costs which health care providers incur in delivering services; must now set reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services; and that states must now rely on studies of provider costs as a basis for their Medicaid rate setting.

The Ninth Circuit's interpretation of 42 U.S.C. § 1396a(a)(30)(A) would contradict legislative intent and render superfluous 42 U.S.C. § 1396a(a)(13)(A) ("the Boren Amendment"), which governs rate-setting for inpatient hospital services, nursing homes and intermediate care facilities for the mentally retarded. In distinguishing the requirements imposed upon states by

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Record regarding beneficiaries' access to services and failed to recognize the Department's supplementary studies of hospital cost.

4. The standard of review of agency rate-setting is highly deferential. The agency's action is presumed valid if a reasonable basis exists for its decision. *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110, 116 (C.D. Cal. 1982), aff'd 705 F.2d 466 (9th Cir. 1983). The state agency is merely required to undertake a "reasonably principled analysis" of its Medicaid rates. *Folden v. Washington State Dep't of Social and Health Servs.*, 744 F. Supp. 1507, 1532 (W.D. Wash. 1990), aff'd 981 F.2d 1054 (9th Cir. 1992). This Court stated in *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 415 (1971) that the agencies' decisions are "entitled to a presumption of regularity." Under the arbitrary and capricious standard established by this Court, the Hospitals should have been required to demonstrate that the Department could not have reasonably believed that the Medicaid rate increases enacted would be consistent with the statutory factors of efficiency, economy, quality of care, and access.

the Boren Amendment from those imposed by 42 U.S.C. § 1396(a)(30)(A), the Department queried whether 42 U.S.C. § 1396a(a)(30)(A) creates a private right of action for health care providers under 42 U.S.C. § 1983. This court ruled in *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 517-521 (1990) that the Boren Amendment does create such a private right of action, but has not addressed whether providers may bring a private right of action for alleged violations of 42 U.S.C. § 1396a(a)(30)(A).

The Court's authoritative guidance on these important questions of federal law is vital. Compelling reasons exist for granting this petition for writ of certiorari to resolve the conflict among the Courts of Appeals.

ARGUMENT

I. CERTIORARI SHOULD BE GRANTED BECAUSE THE DECISION OVERLOOKS THE STATUTE'S PLAIN LANGUAGE AND THE LONGSTANDING FEDERAL INTERPRETATION OF 42 U.S.C. § 1396a(a)(30)(A). THE NEW PAYMENT STANDARD ESTABLISHED BY THE NINTH CIRCUIT RULING LACKS SUPPORT IN STATUTORY OR REGULATORY HISTORY AND CONFLICTS WITH THE SEVENTH AND EIGHTH CIRCUITS' READING.

Nothing in case law or the legislative history of 42 U.S.C. § 1396a(a)(30)(A) (summarized in the Administrative Record and the Ninth Circuit briefs) supports the interpretation that this provision imposes a cost-based minimum payment standard for Medicaid reimbursement rates. This is the first time that a federal court has interpreted the statute as imposing a specific payment standard based on provider costs in the 29-year history of the "efficiency, economy, and quality of care"

provision of 42 U.S.C. § 1396a(a)(30)(A). It is likely that a payment standard based on provider costs has never been applied by any third-party payor (i.e., Medicaid, Medicare, or private health insurance) in setting rates for outpatient services.

Indeed, the Ninth Circuit's ruling directly conflicts with *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996). The Seventh Circuit stated:

> "Nothing in the language of 42 U.S.C. § 1396a(a)(30), or any implementing regulation, requires a state to conduct studies in advance of every [Medicaid rate] modification. It requires each state to produce a result, not to employ any particular methodology for getting there. Section 1396a(a)(30)(A) is in this respect unlike the Boren Amendment, which requires the state to adopt rules that 'the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate' to achieve identified objectives. The Court concluded in *Wilder* that a state could not make the necessary findings and assurances without conducting a study. [Citation omitted.] Under § 1396a(a)(30), however, states may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30)(A), must) raise the price until the market clears." (Id. at 1030.)

Similarly, in *Minnesota Homecare Association, Inc., et al. v. Gomez*, No. 96-1736, 1997 U.S. App. LEXIS 4726 (8th Cir. March 14, 1997), the Eighth Circuit also ruled that 42 U.S.C. § 1396a(a)(30)(A) does not require the state to utilize any prescribed method of analyzing and considering the factors of efficiency, economy, quality of

care, or access to services in the process of setting or changing Medicaid reimbursement rates.[5]

In contrast to the rulings of the Seventh and Eighth Circuits, the Ninth Circuit ruled herein that 42 U.S.C. § 1396a(a)(30)(A) does require states to employ a particular methodology and to conduct cost studies in order to comply with the statute.

In reaching this holding the Ninth Circuit commented:

> "a state agency's interpretation of federal statutes is not entitled to the deference afforded a federal agency's interpretation of its own statutes [Citation omitted]." (Orthopaedic, 103 F.3d at 1495).

In so stating, the Ninth Circuit overlooked the federal government's own longstanding interpretation of the "efficiency, economy, and quality of care" provision (42 U.S.C. § 1396a(a)(30)(A)). This novel deviation was crucial because the statute is reasonably interpreted as being concerned with efficiency and economy in a state's administration of its Medicaid program, rather than with compensating some portion of the costs of efficient and economic providers. The plain language of § 1396a(a)(30)(A) supports the fact that the "efficiency, economy, and quality of care" provision does not establish any kind of minimum payment standard. The statute is completely devoid of any reference whatsoever to provider costs. Section 1396a(a)(30)(A) merely provides that

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5. Also, for example, in *Fulkerson v. Com'r Maine Dep't of Human Services*, 802 F.Supp. 529, 534 (D.Me. 1992) the court held that while the "access" provision is judicially enforceable, the "efficiency, economy, and quality of care" provision was "too vague and amorphous and therefore beyond the competency of the judiciary to enforce."

payments are to be "consistent" with efficiency, economy, and quality of care" and "sufficient to enlist enough providers" so that there is access to services comparable to that available to the general population in the geographic area. Congress expressly chose to use the word "sufficient"[6] to qualify the access requirement only. The term "sufficient" is placed after the "efficiency, economy, and quality of care" provision. Had Congress intended to use the "efficiency, economy, and quality of care" criteria to impose a minimum payment standard, it would have required that payments be "sufficient" (i.e., high enough) to ensure "efficiency, economy, and quality of care"; it did not do so. 1 AR 15; 3 AR 13 and 16-17.

The Department's Rate Study evaluated a variety of ways in which decisions regarding payment rates and "utilization" (both of which impact payments under 42 U.S.C. § 1396a(a)(30)(A)) relate to "efficiency, economy, and quality of care" in the administration of the Medicaid program. The Department does not take the position that considerations of "efficiency, economy, and quality of care" would never justify an increase in reimbursement. The Department's rate study gave examples of how these statutory factors could justify a rate increase. Rather, the Department's position has consistently been that the "efficiency, economy, and quality of care" provision does not impose any specific minimum reimbursement standard, such as that now established by the Ninth Circuit.

If a statutory provision is ambiguous, courts must interpret the statute based on the federal government's longstanding interpretation. An agency's interpretation of a statutory provision or regulation that it is charged with

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6. "Sufficient" is defined as "adequate for the purpose; enough." Random House College Dictionary, Rev. ed., 1984.

administering is entitled to a high degree of deference. *Chevron U.S.A., Inc. v. Nat'l Resources Defense Council*, 467 U.S. 837, 843 n.9 (1984). *Todd Shipyards v. Director, Office of Workers Compensation Programs*, 950 F.2d 607, 610 (9th Cir. 1991).

As summarized in the Rate Study, the federal government from 1967 on has consistently interpreted the "efficiency, economy, and quality of care" provision as imposing an upper limit on state spending and has never interpreted it as imposing any kind of minimum payment standard tied to provider costs. Title 42 Code of Federal Regulations ("C.F.R."), § 447.300 specifies that §§ 447.302 through 447.361 implement the "efficiency, economy, and quality of care" provision of 42 U.S.C. § 1396a(a)(30)(A). The regulations set no cost-based requirements. To the contrary, the only element these regulations contain are upper limits on Medicaid spending.[7]

The legislative and regulatory history does not support the Ninth Circuit's interpretation of 42 U.S.C. § 1396a(a)(30)(A). Enacted as a cost-containment measure, the original statute imposed a two-tiered payment ceiling, in which payments must not be more than is consistent with "efficiency, economy, and quality of care" and also must not exceed an absolute maximum of "reasonable charges."

Language in the Budget Committee Report concerning the 1981 repeal of the "reasonable charges" language establishes that the "efficiency, economy, and quality of care" language was not intended to set any kind

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7. 42 C.F.R. § 447.321 provides that payments for hospital outpatient services may not exceed total payments that would be made to providers under the Medicare program. 42 C.F.R. §§ 447.332 and 447.361 also impose upper limits on spending.

of minimum payment standard. Rather, the Budget Committee stated that the purpose of the amendment was to provide states "with the flexibility to create incentives to improve the availability and utilization of physician services under Medicaid". 1 AR 10. The Budget Committee also indicated that removal of the Medicare "reasonable charges" ceiling would "help simplify the states' administration of the Medicaid program." It noted that some states had difficulty getting Medicare prevailing charge data and others had difficulty setting a statewide rate. 1 AR 10-11; 2 AR 27-28.

The Budget Committee also commented that states "face clear cost pressures in their medical programs" and therefore, states were encouraged "to improve the administration of" these programs and try innovative approaches to physician payment, rather than merely raising physician fees above Medicare levels." Clearly, Congress intended to give states flexibility to control the costs of administering the Medicaid program. Nothing in the history indicates that Congress' concern was adequate compensation of provider costs. 2 AR 27-28; 3 AR 14-15.[8]

The Budget Committee also noted that it expected states "to be free to design their reimbursement systems to provide incentives for the provision of primary care over specialty care or to reduce urban-rural differential in payment levels". 3 AR 15. This flexibility is contrary to the notion that the "efficiency, economy, and quality of care" criteria were intended to set any minimum payment standard.

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8. When compensation of provider costs is the goal, Congress has clearly expressed it, as in the Boren Amendment.

At no time during the 13 year history between enactment of the "efficiency, economy, and quality of care" provision, and the enactment of the Boren Amendment, did Congress, the federal government, or any court, ever indicate that 42 U.S.C. § 1396a(a)(30)(A) required compensation of any portion of the costs of efficient and economic providers to provide quality care.

Congress first introduced the concept of paying rates that compensate the costs of efficiently and economically operated providers to provide quality health care when it enacted the Boren Amendment in 1980. When the federal government adopted regulations implementing the Boren Amendment, it discussed the "efficiency, economy, and quality of care" provision, stating:

> "The Medicaid law did not initially include any specific requirements regarding the methods of payment to be used to pay for either [Skilled Nursing Facility] or [Intermediate Care Facility] services. As a result, individual States were permitted to develop their own payment methods, subject only to the general requirement, . . . that payments not exceed reasonable charges consistent with efficiency, economy, and quality of care. Under the initial Medicaid law, states developed a variety of payment methods. These methods ranged from the retrospective, reasonable cost reimbursement system used by Medicare . . . to prospective rates based, in some instances, on state budgetary considerations and other factors not directly related to actual . . . costs. (Emphasis added). (46 Fed. Reg. 47, 964 (Sept. 30, 1981).)

Significantly, the federal government stated that the "efficiency, economy, and quality of care" language imposed only a "general requirement" under which rates

were sometimes based on budgetary considerations and other factors unrelated to provider costs. Later discussing a federal upper limit on aggregate state spending for inpatient services at 42 C.F.R. § 447.272, the federal government said it was intended to meet "the separate requirement . . . that payments be consistent with efficiency, economy, and quality of care." (48 Fed. Reg. 56,054 (Dec. 19, 1983). See also 2 AR 399-491 concerning the federal implementation of 42 U.S.C. § 1396r-7.

This Court previously noted that the Boren Amendment expressly required "reasonable and adequate" rates judged "against the objective benchmark of an "efficiently and economically operated facility."' *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 517-521 (1990). A court may not find that the "efficiency, economy, and quality of care" provision imposes a Boren Amendment payment standard based solely on a linguistic similarity between some of the words used in the two statutes. "That is not the end of the matter" for a court, which must take "pains to analyze the statutory provisions in detail, in light of the entire legislative enactment." *Suter v. Artist M.*, 503 U.S. 347, 357 (1992).[9] This Court has made it clear that such evaluation must also consider federal regulations implementing the federal statute (*Wilder* at 519 and *Wright v. Roanoke Redevelopment and Housing*, 479 U.S. 418, 430 (1987).

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9. In light of the enactment of section 211 of the Social Security Act Amendments of 1994 (Pub. L. No. 103-432, § 211) codified at 42 U.S.C. § 1320a-10, *Suter* is cited herein only for the guidance it provides as to application of the grounds (set out in prior Supreme Court decisions) for determining the availability of a private right of action under 42 U.S.C. § 1983.

II. THERE IS NO VIOLATION OF A COGNIZABLE FEDERAL RIGHT SUFFICIENT TO SUPPORT AN ACTION BY HEALTH CARE PROVIDERS UNDER 42 U.S.C § 1983

A. Health Care Providers Have No Federal Right Under This Statute

The Department submits that 42 U.S.C. § 1983 affords providers no tangible federal right under 42 U.S.C. § 1396a(a)(30)(A). An action will not lie under 42 U.S.C. § 1983 unless the underlying federal statute provides a plaintiff with enforceable substantive rights.

Where a federal statute imposes a specific obligation on the state, there may be an enforceable private right. Where, as under 42 U.S.C. § 1396a(a)(30)(A), a statute imposes only the generalized duty that a state have a plan approved by the federal government, there is no such right.

42 U.S.C. § 1396a(a)(30)(A) was not enacted to benefit health care providers. Rather, it is a cost-containment provision which sets a ceiling for Medicaid reimbursement (rates must be "consistent with efficiency and economy") and it provides a benefit to Medicaid beneficiaries by ensuring them access to quality health care (rates must be "consistent with . . . quality of care" and ensure access).

In *Suter*, this Court held that private individuals did not have the right under 42 U.S.C. § 1983 to enforce provisions of the Adoption Assistance and Child Welfare Act of 1980 (Adoptions Act), 42 U.S.C. §§ 620-628, 670-679(a). This Court in *Suter* distinguished *Wilder* and *Wright* on the ground that the statutes at issue there actually imposed direct obligations on the state. It noted

that in *Wilder*, the Boren Amendment "actually required the states to adopt reasonable and adequate rates." (*Suter*, 503 U.S. at 357-359). It follows that it is the "reasonable and adequate" rate language of the Boren Amendment that indicates an intent to benefit providers. The only comparable requirement in 42 U.S.C. 1396a(a)(30)(A) is the "sufficient" payment requirement, which applies only to the "access" provision. Yet, there is no comparable indication in the statute indicating that the "efficiency, economy, and quality of care" provision was intended to benefit providers. The only federal regulatory guidance on the issue are the payment upper limits, which are consistent with an intent to control program spending, and not benefit providers.

In distinguishing *Wilder*, this Court noted in *Suter* that the Adoptions Act provided no guidance as to how a state's "reasonable efforts" were to be measured and that a state's compliance with this directive is, within broad limits, left to the state. (*Suter*, 503 U.S. at 360).

The same is true with respect to the provisions of 42 U.S.C. § 1396a(a)(30)(A) at issue here. Within broad federal rules, each state decides the reimbursement rates for services. The state has wide discretion to design and administer its local program. (*Lewis v. Hegstrom*, 767 F.2d 1371, 1373 (9th Cir.1985).) But there is nothing in 42 U.S.C. 1396a(a)(30)(A) or related federal regulations providing any guidance as to a minimum standard for setting rates (e.g., provider costs, provider charges or third party payments). Moreover, there is nothing in the statute or federal regulations providing any guidance as to the percentage of any such standard that rates would need to be set (e.g., 100, 80, 60 percent, etc.). The Boren Amendment contains an express cost based standard (i.e., "costs" of "efficiently and economically operated facilities") and states rates must be "reasonable and adequate" to

"meet" those costs. Such precise guidance is completely lacking with respect to the "efficiency, economy, and quality of care" provision. The only guidance provided by the federal government is that payments may not exceed upper limits on spending contained in federal regulations.

Thus, in *Suter* this Court noted that other provisions of the Adoptions Act indicated that Congress knew how to impose precise requirements on the states aside from the submission of a plan when it intended to. (*Suter*, 503 U.S. at 361, fn. 12.) The same is true with respect to 42 U.S.C. § 1396a. Though Congress did not do so in 42 U.S.C. § 1396a(a)(30)(A), in the Boren Amendment (which was at issue in *Wilder*), Congress did impose precise requirements on the states.

The statutory provision relied upon by the Hospitals herein (42 U.S.C. § 1396a(a)(30)(A)) is simply a communication to the Secretary of United States Department of Health and Human Services and does not impose any specific obligations on the states.

This Court also noted in *Suter* that since other provisions of the Adoptions Act provided enforcement mechanisms, the lack of a private remedy did not make the "reasonable efforts" clause a "dead letter." (*Suter*, 503 U.S. at 360-361). Again, the same is true here. Comparable to the enforcement mechanism identified in the Adoptions Act, 42 U.S.C. § 1396c provides an enforcement mechanism for State Plan requirements.

B. Because the Rate Provisions of 42 U.S.C. § 1396a(a)(30)(A) Are So Vague, No Judicially Enforceable Right Is Conferred for a 42 U.S.C. § 1983 Action.

"In all cases, the availability of the section 1983 remedy turns on whether the statute, by its terms or as interpreted, creates obligations 'sufficiently specific and definite' to be within 'the competence of the judiciary to enforce . . . .'" (*Wright*, 479 U.S. at 432).

In *Martinez v. Wilson*, 32 F.3d 1415 (9th Cir. 1994), the Ninth Circuit dismissed plaintiffs' claim, ruling that they did not have a right, enforceable under 42 U.S.C. § 1983, to challenge the weights which the California Department of Aging had assigned to particular factors in a new funding formula ("IFF") under the Older Americans Act.[9] The Ninth Circuit, citing *Suter*, stated:

> "Beyond the vague requirements that the IFF 'take into account' or pay 'particular attention' to certain categories of older individuals, the Act provides no guidance as to how these phrases should be translated into specific percentages in any IFF. There are no judicially manageable standards here. . . . We conclude that the Act leaves the State with the discretion, within . . . broad limits . . . and subject to the Secretary's approval to determine the degree to which the IFF takes into account or reflects each mandated characteristic. In this circumstance, the Cities do not have a right, enforceable under 42 U.S.C. § 1983, to challenge the weights assigned to the particular factors in the new IFF." (*Martinez*, 32 F.3d at 1421).

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9. 42 U.S.C. § 3001 et seq.

Akin to the Older Americans Act, 42 U.S.C. § 1396a(a)(30)(A) lists the statutory factors for establishing Medicaid payments ("efficiency", "economy", "quality of care" and access), but does not provide any "judicially manageable standards" as to how to define these factors, nor does the statute provide guidance as to how to weigh the factors in formulating rates. Thus, health care providers simply do not have an enforceable right under 42 U.S.C. § 1983.

III. THE NEW PAYMENT STANDARD WILL CREATE ADMINISTRATIVE CHAOS FOR THE STATES: IT IS NOT A FEASIBLE STANDARD FOR THOUSANDS OF SEPARATE MEDICAL SERVICES, SUPPLIES, DRUGS, ITEMS, AND EQUIPMENT, AND IT WILL TAKE MANY YEARS AND MANY ADDITIONAL STATE EMPLOYEES TO SET RATES PURSUANT TO SUCH A PAYMENT STANDARD.

A. Data Collection Problems:

The Ninth Circuit's reading of 42 U.S.C. § 1396a(a)(30)(A) imposes nearly insurmountable data collection problems on the states. As the Ninth Circuit noted, the Boren Amendment requires inpatient providers to submit cost reports. (*Orthopaedic*, 103 F.3d at 1499). These statutorily-required cost reports provide data used to set rates, pursuant to the Boren Amendment. Under current Medi-Cal statutes and regulations and presumably those of other states, there is no such mechanism for gathering cost data to even begin the daunting process of trying to determine the costs of an efficient and economic provider with respect to non-inpatient services. It is unlikely that non-inpatient service providers maintain anything comparable to a cost report for each of the many thousands of non-inpatient medical services, equipment,

supplies, and items. (Appendix E-- Taylor Declaration, ¶ 27 filed in Ninth Circuit in support of Department's Motion for Stay of Mandate).

Because no federal statute or regulation requires non-inpatient providers to provide cost data, states would need to take immediate action to adopt procedures and rules concerning what sort of cost data is needed. Providers are generally reticent about providing cost data and may well file legal challenges to such a requirement.

Another problem is that this new payment standard requires states to determine the costs of an efficient and economic provider to provide "quality care." While the Department has statutory responsibility for licensing and surveying the quality of health care provided by California hospitals and nursing homes, there has seldom been a focus on evaluating quality of care on a service specific basis given the over 20,000 different services provided by hospitals. Moreover, the Department does not have responsibility for licensing the thousands of services, items, and supplies Medi-Cal covers outside of an institutional setting. Much of the data needed to evaluate quality would likely be confidential and unavailable to the Department or other states for use in rate-setting. (Appendix E, ¶ 27.)

B. Problems Caused by the Existence of Many Thousands of Different Non-Inpatient Services:

When setting rates under the Boren Amendment to compensate the costs of efficiently and economically operated providers, a state sets rates for only three broad categories of services: hospital inpatient services, nursing home services, and services in intermediate care facilities for the mentally retarded. With the cost data providers submit pursuant to the Boren Amendment, the

Department and other states are able to estimate the average daily costs of providing these services. The reimbursement rates established bear a relationship to the daily costs. Separate rates are not established for each specific service commonly provided as part of daily inpatient services. Thus, a state can evaluate the relative efficiency and economy of inpatient provider costs based on the projected average daily costs for all services compensated by the daily rate. (*See generally*, Boren Amendment.)

There are monumental difficulties inherent in requiring states to establish rates that compensate the costs of efficient and economic providers of non-inpatient services. Non-inpatient services are not paid on a daily rate basis and separate rates are established for each of the thousands of different medical services, equipment, supplies, and items.[11/]

There are approximately 20,000 separate hospital outpatient services reimbursed pursuant to 22 Cal.Code Regs. § 51509. There are at least 20,000 non-hospital outpatient services. For example, there are at least 11,000 separate physician services reimbursed under 22 Cal. Code Regs. § 51503.[12/] There are thousands of others.

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11. See, e.g. Medi-Cal regulations at title 22 Cal. Code Regs. §§ 51503, 51503.1, 51503.2, 51505.1, 51505.2, 51505.3, 51506, 51506.1, 51507, 51507.1, 51507.2, 51509, 51514, 51514.5, 51515, 51516, 51516.1, 51517, 51518, 51519, 51519.2, 51521, 51527, 51529, 51531, and 51533, which set forth Medi-Cal rates for most of the medical services and items for which the Boren Amendment does not apply.

12. 22 Cal. Code Regs. § 51515 alone lists approximately 1,000 different prosthetic and orthotic items for which a reimbursement rate is established. Similarly, there are nearly 200 dental procedures (§ 51506) and more than 100 vision-related services and

Providers may argue the new standard applies to all of these.

Unlike inpatient services, a daily rate is not paid for other covered Medi-Cal or Medicaid services. Efficiency and economy must, thus, be separately considered for each of these thousands of individual medical services, equipment, supplies, and items.

Pursuant to the Ninth Circuit ruling, the Department and other states would have to undertake the gargantuan task of gathering cost data and quality care data on these thousands of different Medicaid and Medi-Cal services. They would then have to determine, based on available data, the costs of an efficient and economic provider to provide each and every one of these thousands of different medical services, equipment, supplies, and items. Having done that, the Department and other states would then have to decide what portion of those costs are reimbursable (i.e., what constitutes a "reasonable relationship" between provider costs and the Medi-Cal or Medicaid rate for each of the thousands of different covered services). Because for example, there are at least 20,000 different hospital outpatient services, supplies, and other covered items in California alone, it could take the Department many years to initially review and adopt hospital outpatient rates in accordance with the Ninth Circuit's new payment standard. It could take even longer to adopt new rates for the thousands of additional medical services, equipment, supplies, and items Medicaid and specifically Medi-Cal program covers. Each state would have to continually monitor rates and provider costs in

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durable medical equipment (§ 51521) and literally thousands of different reimbursable drugs (§§ 51513.5, 51513.6). There are also hundreds of podiatry, psychology, orthodontic, physical therapy, occupational therapy, speech therapy, and audiology services.

order to maintain rates at a level bearing a reasonable relationship to the costs of efficiently and economically providing each and every one of these thousands of covered services. This additional supervision would require hiring a staggering number of additional state employees to implement this novel mandate, placing a tremendous burden on taxpayers.

IV. THE DECISION IMPOSES A POTENTIALLY DEVASTATING FISCAL IMPACT ON THE STATES AND FEDERAL GOVERNMENT

The cost impact of the Ninth Circuit's decision could be **hundreds of millions of dollars** annually for just hospital outpatient services (Appendix E, Taylor Decl., ¶ 25). The fiscal impact of state court actions for retroactive relief could be **billions of dollars.** There is also a huge potential fiscal impact if other types of providers file suits based on a belief that the decision is applicable to rate-setting rates for all other Medicaid services.

V. THE NINTH CIRCUIT'S DECISION IS LIKELY TO RESULT IN AN EXPLOSION OF EXTREMELY COMPLICATED RATE LITIGATION IN THE FEDERAL COURTS

A review of federal court decisions in Boren Amendment cases demonstrates the complexity of litigating and deciding a Boren Amendment case. *See, e.g. New Jersey Hosp Ass'n v. Waldman*, 73 F.3d 509 (3rd Cir. 1995); *Indiana Ass'n of Homes for the Aging, Inc. v. Indiana Office of Medicaid Policy*, 60 F.3d 262 (7th Cir. 1995). It is likely that this opinion will lead to an explosion of highly complex Medicaid rate litigation which would require the federal courts to micro-manage each state's Medicaid rate-setting.

This opinion opens the door to an explosion of litigation concerning (1) the nature and sufficiency of cost and quality of care data the state considers, (2) the validity of a state's quality of care assessment, (3) the validity of a state's determination of what constitutes an efficient and economic provider, (4) the validity of a state's determination of efficient and economic costs, and (5) whether the level of reimbursement established was reasonably related to the costs of efficiently and economically providing a service. Pursuant to this ruling, courts may be called upon to separately adjudicate the above issues respecting Medicaid rates for each of the thousands of Medi-Cal covered services, items, and supplies.

An example of the enormous difficulties in such litigation can be seen in the flaws of the Ninth's Circuit's own opinion. The Court's opinion concluded that the rate-setting at issue was insufficient under the Court's construction of 42 U.S.C. § 1396a(a)(30)(A) because the Rate Study took inadequate account of the Court's new standard based on hospital costs. However, in reaching this conclusion, the Ninth Circuit (1) overlooked specific well-documented evidence in the Administrative Record regarding access to providers other than hospitals and (2) failed to take account of other specific evidence in the Administrative Record regarding reimbursements as related to costs. The court's opinion was therefore incorrect as a matter of fact and erroneous as to its conclusion. (Petition for Rehearing, pp. 12-14.) The Ninth Circuit fully overlooked a comprehensive study included and discussed in the Administrative Record and referenced in the Department's briefs.[12/]

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12. The specific study by the Department concluded that access, measured by both units of service and users of service, to outpatient services in physician office settings, clinics, and hospitals had grown

The Ninth Circuit also overlooked that there were more users of physician services than hospital outpatient services in each of the nine years evaluated. 2 AR 385-386.[13] Finally, the Ninth Circuit took no account of data in the Administrative Record that demonstrated a strong, rational correlation of the Department's rates to hospital costs. (3 AR 21; 3 AR 48-52.)[14]

The significance to this Court of these errors is not to reargue their weight or merit, but to underscore that a Circuit Court of Appeal, with all of its resources, failed fully to grasp important, well-documented factual components of an exemplary piece of litigation. If the Ninth Circuit's ruling were to stand, it is apparent that district and appellate courts would encounter equally serious difficulties in addressing the weighty, complex, and highly technical data presented in such litigation. It is exactly the difficulty of resolving this data on a judicial level which militates against the Ninth Circuit's new

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at a rate comparable to, or much greater, than the growth in the Medi-Cal eligible population from 1984 to 1992. (1 AR 45-46; 2 AR 383-87; 3 AR 44.)

13. The overall increase in Medi-Cal "eligibles" or beneficiaries during the period was 67.8%. In comparison, the total number of users of outpatient services increased as follows: physicians - 66.7%; outpatient clinics - 238.7%; county hospitals-148.4 %; all hospitals - 108.3%. For total outpatient "units" of service (e.g., X-rays, pharmaceutical script), the increase in access was similar. Increases were: physicians - 71.4%; outpatient Clinics - 230.9%; county hospitals - 120.9%; all hospitals - 112.2%. (1 AR 46; 2 AR 384).

14. The Department also demonstrated a high correlation between the percentage of hospital business involving Medi-Cal patients and total Medi-Cal reimbursement of costs. In short, the more Medi-Cal business a hospital did, the larger percentage of its costs were recovered. At least one-third (34%) of participating hospitals were reimbursed at least 100 percent of their hospital costs. (3 AR 21-22.)

standard, inviting wholesale micro-management and judicial review of complex Medicaid rate-setting.

CONCLUSION

Accordingly, for the foregoing reasons, petitioner respectfully prays that a writ of certiorari issue to the United States Court of Appeals for the Ninth Circuit, in the case at bar.

Dated: April 24, 1997

Respectfully submitted,

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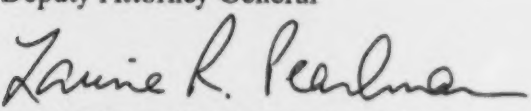

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APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ORTHOPAEDIC HOSPITAL and the CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS,
Plaintiffs-Appellants,

v.

KIMBERLY BELSHE, Director of the State Department of Health Services, State of California,
Defendant-Appellee.

No. 95-55607

D.C. No. CV-94-4764 SVW (JRx)

OPINION

Appeal from the United States District Court
for the Central District of California
Stephen V. Wilson, District Judge, Presiding

Argued and Submitted
August 9, 1996—Pasadena, California

Filed January 9, 1997

Before: Betty B. Fletcher and A. Wallace Tashima, Circuit Judges, and Jane A. Restani,* Judge, U.S. Court of International Trade

Opinion by Judge Fletcher

*Honorable Jane A. Restani, United States Court of International Trade, sitting by designation.

SUMMARY

Health/Medicaid/Medicare and Government Assistance

The court of appeals reversed a judgment of the district court. The court held that when setting reimbursement rates for hospital providers of outpatient services to Medicaid recipients, a state must consider the effect of hospital costs on the statutory factors of efficiency, economy, quality of care, and access.

Among the health-care services that must be provided by states participating in the federal Medicaid program are hospital outpatient services. Although some services provided by hospital outpatient departments can be provided more economically by non-hospital providers like clinics or doctors' offices, hospital outpatient services are more widely available to beneficiaries of Medi-Cal, California's version of Medicaid.

Appellee California Department of Health Services (DHS) set reimbursement rates for hospital providers of outpatient services to Medi-Cal beneficiaries without considering the hospitals' related costs.

Appellant Orthopaedic Hospital brought an action challenging the adequacy of certain of the reimbursement rates set by DHS for hospitals providing outpatient services to Medi-Cal beneficiaries. The district court identified the dispositive issue as whether, as part of the State's obligation under the Medicaid Act to set payment rates consistent with efficiency, economy, quality of care and access, the State had to provide higher payments to hospitals for provision of outpatient services because they incur higher costs than other types of providers.

The district court concluded that DHS was not statutorily required to consider the hospitals' costs. In the court's view,

it would have been inefficient and uneconomical to set rates that compensated hospitals for their costs because hospitals are the most expensive providers of outpatient services. The court reasoned that states should be able to provide incentives for one type of care over another.

[1] Under the Medicaid Act, a state plan for medical assistance must assure that payments are consistent with efficiency, economy and quality of care, and that payments are sufficient to enlist enough providers. [2] DHS must set hospital reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless it shows some justification for rates that deviate substantially from such costs.

[3] DHS cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services. Payments for hospital outpatient services must bear a reasonable relationship to the costs of providing quality care incurred by efficiently and economically operated hospitals. [4] For payments to be consistent with efficiency, economy and quality of care, they must approximate the cost of quality care provided efficiently and economically.

[5] Undercompensating hospitals gives no incentives to Medi-Cal beneficiaries to use more economical providers unless it results in a cessation of the delivery of emergency services by hospitals. It does nothing to shift users to more efficient and economical delivery of care outside the hospital setting.

[6] It appeared that Congress intended payments to be flexible within a range; payments should be no higher than required to provide efficient and economical care, but high enough to provide for quality care and to ensure access to services. [7] States should be free to design reimbursement systems to provide incentives for provision of primary care over

specialty care, or to reduce the urban-rural differential in payment levels. Undercompensating hospitals cannot achieve these goals.

[8] De facto access does not satisfy the requirement that payments must be sufficient to enlist enough providers. A hospital's only option to avoid accepting insufficient Medicaid reimbursements is to close its emergency department or stop accepting federal funds through Medicare. [9] However, since most hospitals accept Medicare patients and operate emergency departments, and may have public service missions to provide care regardless of patients' ability to pay, current provider participation by such institutions is assured.

[10] DHS did not seek to shift services to entities that could provide them more economically and efficiently, but rather to force hospitals to provide the services and to shift the costs to other patients. This technique of underpayment for services was not economical, efficient, or attentive to adequate access. Absent some justification from DHS, reimbursement rates must ultimately bear a reasonable relationship to costs.

[11] DHS failed to consider that the majority of outpatient services are provided in hospitals and that the majority of hospital outpatient services are in the emergency room. Emergency rooms are overused precisely because they are the only accessible providers of primary care for Medicaid recipients. DHS cannot ensure access by requiring hospitals to treat patients in the emergency room, and then refusing to pay the costs of such treatment because theoretically it could have been provided more efficiently elsewhere.

[12] Because DHS did not base its rates on the conclusion that they adequately reimbursed provider costs, its actions were arbitrary and capricious, and contrary to law.

COUNSEL

Lloyd A. Bookman, HOOPER, LUNDY & BOOKMAN, Los Angeles, California, for the plaintiffs-appellants.

Laurie R. Pearlman, Los Angeles, California; Jonathan R. Davis, Los Angeles, California, for the defendant-appellee.

OPINION

FLETCHER, Circuit Judge:

Plaintiffs-Appellants Orthopaedic Hospital and the California Association of Hospitals and Health Systems claim that Defendant-Appellee Director of the California Department of Health Services violated section 1396a(a)(30)(A) of the federal Medicaid Act, 42 U.S.C. §§ 1396a-1396v (West 1992 & Supp. 1996) by setting reimbursement rates for hospital providers of outpatient services without proper consideration of the effect of hospital costs on the relevant statutory factors: efficiency, economy, quality of care, and access. The district court granted summary judgment in favor of the Director. We reverse and remand with direction.

FACTUAL BACKGROUND & PROCEDURAL HISTORY

I. The Medi-Cal Program

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396a-1396v (the "Medicaid Act"), authorizes federal grants to states for medical assistance to low income persons who are aged, blind, disabled, or members of families with dependent children. The program is jointly financed by the federal and state governments and administered by the states. The states, in accordance with federal law, decide eligible beneficiary groups, types and ranges of service, payment levels for ser-

vices, and administrative and operating procedures. Payment for services is made directly by the states to the individuals or entities that furnish the services. 42 C.F.R. § 430.0. To receive matching federal financial participation for such services, states must agree to comply with the applicable federal Medicaid law.

Among the health care services that must be provided by states participating in Medicaid are the medical services at issue in this case — hospital outpatient services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(2)(A). Hospital outpatient services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients by an institution that is licensed as a hospital. 42 C.F.R. § 440.20(a).

Many procedures that once required a lengthy inpatient stay, can now be provided on an outpatient basis. This factor, and the desire to cut costs associated with inpatient stays, has led to a general shift towards outpatient care. This factor has also lead to an increase in the complexity of services provided on an outpatient basis.

Some of the services provided by hospital outpatient departments could be provided more economically by non-hospital providers such as freestanding clinics or doctors' offices because those providers have lower fixed costs than do hospitals. However, hospital outpatient departments are more widely available to Medi-Cal beneficiaries. Hospitals that accept any Medicare payments and operate emergency departments are required by law to examine and (if an emergency medical condition exists) to treat any patient who presents him or herself, regardless of the patient's ability to pay. 42 U.S.C. § 1395dd. In contrast, other outpatient service providers are free to deny care to Medi-Cal recipients and others who are unable to pay for care. With no incentive to use the most economical provider, Medi-Cal beneficiaries frequently choose the more accessible and convenient hospital outpatient

departments over less costly facilities, some of which may be entirely unavailable or less available to them.

The Defendant-Appellee's agency, the Department of Health Services of the State of California, is the state agency responsible for the administration of California's version of Medicaid, the Medi-Cal program. Medi-Cal has a prospective reimbursement system that sets reimbursement rates for specific services, regardless of where those services are performed (e.g., in hospitals, doctors' offices, or freestanding outpatient clinics). Cal. Code Regs. tit. 22, §§ 51501-51557.

Hospital outpatient departments receive an additional reimbursement for room charges, not received by non-hospital providers. Cal. Code Regs. tit. 22, § 51509(g). However, this additional payment is offset by a 20% reduction in the reimbursement rate for physician services furnished in hospital outpatient departments. Cal. Code Regs. tit. 22, § 51503(i). All other outpatient reimbursement rates are the same as those applicable to non-hospital providers. Cal Code Regs. tit. 22, § 51509.

Hospitals which serve a disproportionate share of Medi-Cal beneficiaries[1] and small and rural hospitals are eligible for additional reimbursement from Medi-Cal. However, there are relatively few funds available for these additional payments: $14 million annually. 3 A.R. at 242. In 1991, the total payments for outpatient services were approximately $355 million. 3 A.R. at 436.

The Medicaid Act requires a participating state to develop a state plan which describes the policy and methods to be used to set payment rates for each type of service included in

[1]Hospitals that serve a disproportionately large share of Medi-Cal outpatients as compared to other hospitals receive additional funds. This is calculated annually based on a prescribed formula. *See* Cal. Welfare and Institutions Code § 14105.98 (West. Supp. 1996).

the program. 42 C.F.R. § 447.201(b). California's state plan requires the Department to develop an evidentiary base or rate study, have a public hearing on the proposed rates, determine final rates based on the evidentiary base including public input, and adopt final rates through regulations. However, the state plan also allows the legislature to adjust the rates so long as the requirements of 42 C.F.R. Part 447 are met. Before any rate changes are made, the Department must consult with representatives of concerned provider groups.

In 1982 the California legislature reduced the outpatient reimbursement rates by 10%, and the rates for laboratory services by 25%. In 1984 and 1985 the Department made across the board rate increases resulting in a net increase of 2% over the rates in effect prior to the 1982 reduction. Since 1985 the Department has modified the rates for certain services and has provided additional reimbursement for disproportionate share and small and rural hospitals.

II. Prior Litigation

The Hospitals challenge the adequacy of certain of the reimbursement rates the State of California has set for hospitals that provide outpatient services to Medi-Cal beneficiaries. The reimbursement rates currently in effect were set by the Director upon the district court's remand in *Orthopaedic Hosp. and the Cal. Ass'n of Hosp. and Health Sys. v. Kenneth Kizer, M.D., Director of the Cal. Dep't of Health Serv.*, No. CV 90-4209 SVW (JRx), 1992 WL 345652 (C.D. Cal.) (*"Orthopaedic I"*). The district court reviewed seven specific rate adjustments and found that the Director had acted arbitrarily and capriciously in setting six out of seven of the disputed rates.

It found that (1) efficiency, economy, and quality of care are "relevant factors" under 42 U.S.C. § 1396a(a)(30)(A) and must be considered by the Department when making any rate adjustments; (2) there must be a "rational connection"

between the relevant factors and the rates set; and (3) the Department did not consider the relevant factors in six of the seven rate adjustments at issue.

The district court revised its judgment twice. In its Order Amending the Revised Judgment, it clarified that "[t]he Court has not made any ruling on the validity of the rates themselves and cannot comment on whether the defendant will be able to set similar or identical rates once it conducts a proper inquiry and considers 'efficiency, economy and . . . quality of care.'" In its Second Revised Judgment, the district court ordered that the six improperly promulgated rates would remain in effect until the Department set new rates upon proper consideration of the relevant factors. However, to discourage the Department from delaying reconsideration of its rates, the district court ordered that the new rates were to be applied retroactively from the date of its original summary judgment order.

III. The Remand

Upon remand, the Department conducted a rate study as required by the decision in *Orthopaedic I*. In September 1993, the Department published the results of that study entitled "Consideration of Efficiency, Economy, and Quality of Care and Access with Respect to Changes in Medi-Cal Reimbursement for Hospital Outpatient Services." The Department also issued a Statement of Administrative Decision in which it stated that the Department "does not feel that it is necessary to change Medi-Cal reimbursement for hospital outpatient services from current levels. Having considered efficiency, economy, quality of care and access, the Department has therefore decided to readopt the [existing] reimbursement levels . . . ."

In December 1993 the Department held a public hearing regarding the outpatient rates. The California Association of Public Hospitals and the Plaintiff California Association of

Hospitals and Health Systems submitted public comments and voluminous materials. The Department summarized the public input into an addendum to its rate study.

After the close of public comment and in response to criticism that Medi-Cal outpatient reimbursement rates failed to cover hospitals' costs adequately, the Department commissioned a study by Peterson Consulting. The Peterson study compared total Medi-Cal reimbursement (including inpatient, outpatient, disproportionate share and small and rural hospital reimbursement) to costs for participating California hospitals. The Peterson study concluded that total Medi-Cal reimbursement for inpatient and outpatient hospital services covers at least 100% of the costs incurred by at least 34% of participating hospitals, and 58% of hospitals have 75% of costs covered.

In contrast, an analysis performed for the Hospitals by Dr. Henry Zaretsky concluded that only 0.8% of hospitals were reimbursed 100% of their costs in providing outpatient services, and that 73% of hospitals were reimbursed less than 50% of their costs. Dr. Zaretsky's analysis specifically compared Medi-Cal outpatient reimbursement to costs.

In April 1994 the Department issued its final administrative decision readopting the hospital outpatient reimbursement rates without change.

IV. District Court Review of Readopted Rates

The Hospitals alleging that the Department's readoption of its original rates did not satisfy 42 U.S.C. § 1396a(a)(30)(A) or the mandate of the court in *Orthopedic I*, returned to court filing two actions, Case Nos. 94-4764 and 94-4825 ("*Orthopaedic II/III*"). They were consolidated by the district court.

The district court characterized the chief issue in *Orthopaedic II/III* to be whether, as part of the State's obliga-

tion to set payment rates consistent with efficiency, economy, quality of care and access, "the State must provide higher payments to hospitals for provision of outpatient services because hospitals incur higher costs than other types of providers." The district court concluded that the Department is not statutorily required to consider hospitals' costs when setting reimbursement rates for hospital outpatient services under § 1396a(a)(30)(A).

The district court denied the Hospitals' motion for summary judgment and *sua sponte* awarded summary judgment to the Director. The Hospitals timely appeal.

JURISDICTION

The Hospitals brought their action under 42 U.S.C. § 1983 claiming injury from the Director's violation of 42 U.S.C. § 1396a(a)(30)(A). The district court had jurisdiction under 28 U.S.C. § 1331.

We have jurisdiction under 28 U.S.C. § 1291 over the Hospitals' appeal from the district court's final judgment granting summary judgment to the Director.

STANDARD OF REVIEW

A grant of summary judgment is reviewed de novo. *Warren v. City of Carlsbad*, 58 F.3d 439, 441 (9th Cir. 1995), *cert. denied*, ___ U.S. ___, 116 S. Ct. 1261 (1996).

We review *de novo* a state agency's interpretation of a federal statute. *AMISUB (PSL), Inc. v. Colorado Dep't of Social Serv.*, 879 F.2d 789, 796 (10th Cir. 1989) (reviewing state Medicaid Plan, court subjected state agency's determination of procedural and substantive compliance with federal law to de novo review), *cert. denied*, 496 U.S. 935 (1990); *Turner v. Perales*, 869 F.2d 140, 141 (2d Cir. 1989) (reviewing state department of social services' interpretation of federal hous-

ing assistance law de novo); *Lewis v. Hegstrom*, 767 F.2d 1371, 1376 (9th Cir. 1985) (reviewing construction of Medicaid Act de novo, without deference to state agency's construction).

A state agency's interpretation of federal statutes is not entitled to the deference afforded a federal agency's interpretation of its own statutes under *Chevron, U.S.A., Inc. v. Nat'l Resources Defense Council Inc.*, 467 U.S. 837, 843 (1984). "*Chevron's* policy underpinnings emphasize the expertise and familiarity of the federal agency with the subject matter of its mandate and the need for coherent and uniform construction of federal law nationwide. Those considerations are not apt [to a state agency]." *Turner*, 869 F.2d at 141. What concerns us is whether the state law and regulations are consistent with federal law. Neither the district court nor we defer to the state to answer that question.

DISCUSSION

[1] This appeal turns upon the proper interpretation of 42 U.S.C. § 1396a(a)(30)(A) which states that under the Medicaid Act, a state plan for medical assistance must:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A).

[2] Whether the statute requires the Department to consider the costs hospitals incur in delivering services when setting specific payment rates under § 1396a(a)(30)(A) is the issue. We conclude that the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

[3] The statute provides that *payments* for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients. The Department cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services. It stands to reason that the *payments* for hospital outpatient services must bear a reasonable relationship to the costs of providing quality care incurred by efficiently and economically operated hospitals.

The Department argues that the payments must be *sufficient* (i.e. high enough) to ensure access, but they only need to be *consistent* with efficiency, economy, and quality of care.

[4] It is true that "consistent," not "sufficient," modifies the terms, efficiency, economy, and quality of care. But even "consistency" would appear to require that the Department consider the costs of providing the services for which it is reimbursing. "Consistent" means in agreement with, compatible, or conforming to the same principles or course of action, while "sufficient" means adequate. Webster's II New Riverside University Dictionary, c. 1984. These are not widely different standards. For payments to be consistent with efficiency, economy and quality of care, they must approximate the cost of quality care provided efficiently and econom-

ically. The Department cannot set rates consistent with efficiency and economy in the health care system without considering the costs to the hospitals that provide most of the services. Judgments can be made as to the efficiency of the providers, the economies they practice and the quality of the services they deliver, but costs are an integral part of the consideration.

[5] The district court found that it would be inefficient and uneconomical to set rates that compensated hospitals for their costs since hospitals are the most expensive providers of outpatient services. The district court reasoned that states should be able to provide incentives for one type of care over another. We agree, but undercompensating hospitals gives no incentives to Medi-Cal beneficiaries to use more economical providers unless it results in a cessation of the delivery of emergency services by hospitals. Non-hospital providers are not nearly as available to Medi-Cal beneficiaries as are hospitals. And no lack of economic incentive excuses a hospital that serves Medicare patients from its legal obligation to provide emergency care to all comers if it operates an emergency department. Until the Department provides incentives to non-hospital providers to furnish more services to Medi-Cal beneficiaries, and requires Medi-Cal beneficiaries to utilize non-hospital providers whenever possible, undercompensating hospital outpatient departments does nothing to shift users to more efficient and economical delivery of care outside the hospital setting.

Since the payments themselves must also be consistent with quality of care, the Department must consider the costs of providing quality care. The Department argues that the payments do not independently have to support quality care because quality is assured by other regulations. Essentially, the Department's position is that it doesn't have to pay the costs of quality care because hospitals are contractually obligated to provide quality care once they agree to take Medicaid patients, and because hospitals' licensing requirements

require them to provide quality care. We disagree. The Department, itself, must satisfy the requirement that the payments themselves be consistent with quality care.

Section 1396a(a)(30)(A) originally required that Medicaid payments not be "in excess of reasonable charges consistent with efficiency, economy, and quality of care. . ." The Hospitals interpret this original language to mean that "reasonable charges" were the payment ceiling, and "efficiency, economy, and quality of care" marked the payment floor. The Department asserts that the original language actually set a two-tiered payment ceiling, establishing that payments could be no higher than reasonable charges, and also no higher than what would be consistent with efficiency, economy, and quality of care. Both interpretations are off the mark.

The "in excess of reasonable charges" language was removed in 1981 by § 2174(a) of Public Law 97-35, but the "consistent with efficiency, economy, and quality of care" language remained. Apparently, the reasonable charges standard had been burdensome to administer because it was tied to reasonable charges under Medicare. The Budget Committee Report on the amendment that repealed the "reasonable charges" language expressed that the purpose of the amendment was:

> to remove the administrative burdens this requirement of current law imposes on the States and to provide States with the flexibility to create incentives to improve the availability and utilization of physician services under medicaid.
>
> The Committee believes the removal of the ceiling on physician payments based on medicare will not result in an increase in expenditures for physician services under medicaid. The States all face clear cost pressures in their medical programs. Therefore, the Committee expects this provision will be used by

> the States to improve the administration of their medicaid programs and to try innovative approaches to physician payment rather than merely to raise physician fees above medicare levels.

H.R. Rep. No. 97-158, vol. II, at 312 (1981).

[6] By removing the reasonable charges limitation, Congress wanted to simplify the administrative burden, and allow states more flexibility in devising ways to make services available, while at the same time containing costs. But states still must comply with the efficiency, economy, quality of care, and access standards. It appears that Congress intended payments to be flexible within a range; payments should be no higher than what is required to provide efficient and economical care, but still high enough to provide for quality care and to ensure access to services.

[7] The Budget Committee also noted that states should now "be free to design their reimbursement systems to provide incentives for provision of primary care over specialty care or to reduce the urban-rural differential in payment levels." *Id.* at 313. The Department argues that if reimbursement levels were related to costs, it would be impossible to achieve these goals. But undercompensating hospitals cannot achieve these goals. Incentives to non-hospital providers to treat Medicaid outpatients and encouragement of Medicaid patients to utilize alternate services is required. The Department argued, as an example, that their 1989 reduction in reimbursement for cesarean sections, that was intended to discourage unnecessary cesarean sections, would not have been allowed if the Department had to reimburse at a level that related to the cost of services. But the Department forgets that it is still free to discourage unnecessary procedures through utilization controls without violating § 1396a(a)(30)(A). If a reimbursement rate provides an incentive to use an inappropriate service, then it is not consistent with efficiency, economy, and quality of care.

The equal access to care provision of § 1396a(a)(30)(A) was added by amendment in 1989, although it had been implemented prior to 1989 through federal regulation. 42 C.F.R. § 447.204. In its Rate Study, the Department admitted that the access requirement serves to mandate a minimum payment standard. 1 A.R. at 13. However, the Department contends that in the absence of a de facto access problem, any payment rate would meet this minimum standard.

[8] De facto access, produced by factors totally unrelated to reimbursement levels, does not satisfy the requirement of § 1396a(a)(30)(A) that payments must be sufficient to enlist enough providers. Currently, access appears to be driven to a degree by factors independent of costs of the services. Hospitals that accept any Medicare payments and that operate emergency departments are legally required to treat emergency patients regardless of their ability to pay. 42 U.S.C. 1395dd. Emergency room services represent more than 50 percent of all Medi-Cal payments for hospital outpatient services. 2 A.R. at 60-69; 3 A.R. at 166. Hospitals have a legal obligation to provide those services regardless of the level of Medi-Cal reimbursement rates. Some hospitals also serve patients with non-emergency conditions regardless of their ability to pay because those hospitals have a mission to serve everyone. A hospital's only option to avoid accepting insufficient Medicaid reimbursements is to close their emergency departments or stop accepting any federal funds through Medicare.

[9] In this case there has been no assertion of a provider participation problem. However, as discussed above, any hospital that accepts any Medicare payments and operates an emergency department, cannot opt out of providing emergency care for Medicaid patients, regardless of the reimbursement rates. 42 U.S.C. § 1395dd. Since most hospitals accept Medicare patients and operate emergency departments, and many hospitals have public service missions to provide care regardless of patients' ability to pay, currently provider participation by such institutions is assured.

[10] The compelling "other" reasons for provider participation by such institutions has allowed the Department to ignore the relationship of reimbursement levels to provider costs when determining whether payments are sufficient to ensure access to quality services. The result is that the Department has not sought to shift services to entities that could provide them more economically and efficiently but rather to force hospitals to provide the service and to shift the cost to other patients. This technique of underpayment for services received is not economic, efficient or attentive to adequate access. It is neither economical nor efficient for the system as a whole. The Department need not follow a rigid formula of payments equal to an efficiently and economically operated hospital's costs regardless of other factors such as incentives and utilization controls. But the Department must undertake to determine what it costs an efficient hospital economically to provide quality care. Absent some justification from the Department, the reimbursement rates must ultimately bear a reasonable relationship to those costs.

The Department argues that such an interpretation of § 1396a(a)(30)(A) effectively applies the rate-setting statute for inpatient services, § 1396a(a)(13)(A) (the "Boren Amendment"), to outpatient services. The Boren Amendment requires states to set reimbursement rates based on the costs that must be incurred by efficiently and economically operated hospitals.[2] The Department argues that the lack of such explicit language in § 1396a(a)(30)(A) indicates that Con-

[2]The Boren Amendment requires the Department to set inpatient reimbursement rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services . . . and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital . . . and periodic audits by the State of such reports." 42 U.S.C. § 1396a(a)(13)(A).

gress did not intend provider costs to be a factor in outpatient rates. The Department further argues that requiring the Department to consider costs when setting outpatient reimbursement rates would render the Boren Amendment superfluous.

We disagree. The Boren Amendment requires the Department to make assurances to the Secretary of Health and Human Services that rates are reasonable and adequate to meet the hospitals' costs, and requires periodic cost reports from hospitals subject to audit by the Department. These requirements are not part of § 1396a(a)(30)(A). The requirements of § 1396a(a)(30)(A) are more flexible than the Boren Amendment, but not so flexible as to allow the Department to ignore the costs of providing services. For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs, unless there is some justification for rates that do not substantially reimburse providers their costs.[3]

I. Department's Readoption of Existing Reimbursement Rates

Because the Department must consider hospitals' costs based on reliable information when setting reimbursement rates, we conclude that the Department's readoption of the existing Medi-Cal rates violated § 1396a(a)(30)(A).

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[3]It is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons. *See Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (rejecting budget cutting as a legitimate justification for the approval of a waiver from federal AFDC requirements); *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519, 531 (rejecting "exclusively budgetary" justification for rate cuts to Medicaid providers); *AMISUB v. Colo. Dep't of Social Serv.*, 879 F.2d 789, 800-01 (10th Cir. 1989) (rejecting state Medicaid plan that resulted in 46% reduction in provider reimbursement as being based solely on budgetary constraints: "While budgetary constraints may be a factor to be considered by a state when amending a current plan . . . budgetary constraints alone can never be sufficient."), *cert. denied*, 496 U.S. 935 (1990).

Since the Director maintains that the payments themselves do not have to bear any relationship to hospitals' costs, she does not even argue that the Department considered them. The department's initial reevaluation of its rates consisted of:

> (1) a contrast of program expenses to the statutory Medi-Care ceiling; (2) Departmental and federal utilization controls that assure that the payments are consistent with sound medical policy regarding medical necessity and quality of care; and (3) independent analyses of substitute providers' efficiency, costs and charges and of various other components of the reimbursement system.

Appellee's Brief at 29.

The analysis of substitute providers involved an inquiry into whether non-hospital providers could deliver outpatient services more efficiently than hospital providers. Upon determining that non-hospital providers were more efficient, the Department concluded that "absent an access problem, 'it is not appropriate to pay additional reimbursement to a provider type that (1) is not as cost efficient as other providers in providing the services, or (2) charges the program more than other providers do for the same services.' " Appellee's Brief at 32.

[11] The Department's analysis fails to consider that the majority of outpatient services are in fact provided in hospitals, and that the majority of hospital outpatient services are in the emergency room. The Department contends that it shouldn't have to compensate hospitals for their costs because emergency rooms are overused and are often used for non-urgent conditions. True as this may be, emergency rooms are overused precisely because they are the only accessible providers of primary care for many people, particularly Medicaid recipients. The Department cannot ensure access by relying on regulations requiring hospitals to treat patients in the emer-

gency room, and then refuse to pay the cost of such treatment because theoretically it could have been provided more efficiently elsewhere. Nowhere does it appear that the Department inquired whether Medi-Cal beneficiaries had adequate access to outpatient services in non-hospital settings.

In concluding that the existing payment rates were consistent with quality of care, the Department relied solely upon the fact that hospitals are forced to provide quality care because of other legal and contractual obligations which have nothing to do with the payment rates. Clearly this conclusion was not based on any consideration of the costs of providing quality care.

The Department's initial Rate Study did not include any analysis of the relationship of reimbursement rates to provider costs. Instead, the Rate Study devoted its analysis to supporting the conclusion that "the failure of existing rates to fully compensate providers based upon a cost or charge criterion is not relevant to whether the rates are consistent with efficiency or economy."

After publishing its Rate Study and hearing public comments, the Department did commission a study by Peterson Consulting to evaluate the relationship of reimbursement rates to provider costs. The Peterson study came to conclusions that were markedly different from those in Dr. Zaretsky's analysis for the Hospitals. The main difference in methodology between the two studies is that the Peterson study looked at total Medi-Cal payments to hospitals including inpatient, outpatient and disproportionate share payments, while the Zaretsky analysis looked specifically at outpatient payments.

[12] Both the Hospitals and the Department have numerous quarrels with the validity of each other's data and methodology. The Hospitals also claim that the Peterson study is not legitimately included in the Administrative Record since it was added after the period for public comment had closed.

We need not parse these arguments. Regardless of the merits of the Peterson study, the Department did not base its readoption of existing rates on the conclusion that they adequately reimburse provider costs. Since the Department did not consider hospitals' costs when reevaluating its rates, it has not appropriately applied § 1396a(a)(30)(A). Without an appropriate consideration of the relevant factors, the Department cannot possibly conclude that there is a rational relationship of those factors to the rates set. Therefore, the Department's actions in readopting the original reimbursement rates were arbitrary and capricious, and contrary to law.

CONCLUSION

The proper interpretation of § 1396a(a)(30)(A)'s requirement that payments for services must be consistent with efficiency, economy, and quality of care, and sufficient to ensure access, requires the Department to consider the costs of providing hospital outpatient services. While the Department's hospital outpatient rates should reflect consideration of many factors, they also should bear a reasonable relationship to an efficient and economical hospital's costs in providing quality care. Since the Department did not adequately consider hospitals' costs when readopting its rates, the Department's actions were arbitrary and capricious and contrary to law.

Upon remand, the Department should undertake responsible cost studies that will provide reliable data as to the hospitals' costs in providing outpatient services to the end that it determine the cost to an efficient hospital economically providing quality care. The state must then set rates that have some reasonable relation to such costs, the state bearing the burden of justifying any rate that substantially deviates from such determined costs.

REVERSED and REMANDED.

APPENDIX B

FILED
MAR 20 1995
Clerk, U.S. District Court
Central District of California
By Deputy

CONSTITUTES NOTICE
OF ENTRY REQUIRED
BY FRCP, RULE 77(d)

ENTERED
Clerk, U.S. District Court
MAR 24 1995
Central District of California
By Deputy

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

ORTHOPAEDIC HOSPITAL AND THE CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS,
Petitioner,
v.

KIMBERLY BELSHE, THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA,
Respondent.

AND RELATED CASE

CV 94-4764 SVW (JRx)
CV 94-4825 SVW (JRx)
CONSOLIDATED CASES

ORDER DENYING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND GRANTING SUMMARY JUDGMENT FOR DEFENDANT

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

I. Background

Plaintiffs Orthopaedic Hospital, an acute care hospital, and the California Association of Hospitals and Health Systems, a hospital trade group, seek summary judgment against defendant Kimberly Belshe, Director of the State of Department of Health Services ("the Department" or "DHS") based upon plaintiffs' dissatisfaction with certain reimbursement rates California pays to hospitals that provide outpatient services to beneficiaries of the State's medical assistance program, Medi-Cal.

A. Medicaid Background

Medicaid (Medi-Cal in California) is a cooperative federal/state program jointly funded by the federal and state governments. See 42 U.S.C. § 1395 et seq.[1] A single state agency (DHS in California) administers each state's Medicaid program. § 1396a(a)(5) and 42 C.F.R. §§ 430.10. Among the services that must be furnished under Medicaid are hospital outpatient services. §§ 1396a(a)(10)(A), 1396d(a)(1)-(2).

Participating states must comply with the Medicaid Act. § 1396 et seq. The Medicaid Act provision that addresses payment rates, § 1396a(a)(30)(A), is the focus of this case. It requires each state Medicaid plan

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1. All citations to sections of the United States Code refer to Title 42 unless otherwise noted.

> to provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

§ 1396a(a)(30)(A) (emphasis added).

The State, through its Medi-Cal system, is a purchaser of medical services. It buys the services from those health care providers who elect to treat Medi-Cal beneficiaries. The legal relationship between a provider and the State is contractual in nature. No law requires providers to accept Medi-Cal beneficiaries as patients.

B. Outpatient Services

Unlike inpatient services, which by definition must be provided in a hospital, the vast majority of outpatient services are simply ambulatory medical services that may be rendered in a clinic, a doctor's office, or a hospital.

A prospective, flat rate system is used to reimburse providers for outpatient services. Cal. Code Regs. tit. 22, § 51501 et seq. Hospitals are paid for outpatient services in the same manner and to the same extent that non-hospital providers of outpatient services are paid, i.e., a flat rate for a specific service. The rate paid by Medi-Cal is based on the particular outpatient service provided; it is

not based on where that outpatient service is rendered.[2] Pursuant to the Department's regulations (e.g., Cal. Code Regs. tit. 22, § 51509) and Attachment 4.19-B to the Medi-Cal State Plan, Medi-Cal reimburses the lower of a hospital's usual charges or rates established by the Department for outpatient services.

Hospitals that serve a disproportionate share of Medi-Cal patients and small and rural hospitals receive additional payments. Cal. Health & Safety Code § 118.877, Cal. Code Regs. tit. 22, § 51509(k). The funds available annually under these provisions are relatively small: $10 million for disproportionate share hospitals, and $4 million for small and rural hospitals. See 3 Administrative Record 242 ("AR"). Total payments for hospital outpatient services for the fiscal year ending June 30, 1991 were approximately $355 million. 3 AR 436.

In 1982, the California Legislature mandated that Medi-Cal rates for most services, including hospital outpatient services, be reduced by 10% and that rates for laboratory services be reduced by 25%. The rates were later increased effective August 1, 1984 and August 1, 1985. The net effect was that most rates were increased by 2% over the level in effect prior to the 1982 rate reduction. 3 AR 1156-57. These are rates generally in effect today, aside from a few rate adjustments at issue in this case.

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2. Hospitals are paid more that other providers of outpatient services in one regard. When outpatient services are provided in a hospital setting, the Department pays additional reimbursement to hospitals for "room use." "Room use" fees are not paid to providers rendering the same outpatient services in a non-hospital setting.

The Department argues that hospitals are the "Cadillac" providers of outpatient services. They argue that it is generally more cost efficient to perform an outpatient procedure in a non-hospital setting.

The chief issue in this case is whether the State must provide higher payments to hospitals for provision of outpatient services because hospitals incur higher costs than other types of providers. If so, then seven particular rate-setting decisions of the Department could be invalid under the Medicaid Act.

C. Procedural History

In August 1990 plaintiffs filed a case in this Court (Orthopaedic I"). There, as in this case, plaintiffs alleged that outpatient reimbursement rates paid by California to hospitals which provide outpatient services to Medi-Cal beneficiaries violate state and federal law (including §§ 1396a(a)(13) and 1396a(a)(30)(A)). The Court ultimately granted summary judgment for plaintiffs in large part and defendant in small part. See Order filed October 6, 1992.

Based on its review of the administrative redord filed in Orthopaedic I, the Court determined that the administrative record did not establish that defendant had adequately considered the factors of efficiency, economy, and quality of care in enacting certain particular outpatient rates, but that defendant had adequately considered these factors in enacting certain other outpatient rates.

The Court did not invalidate any of the challenged rates, but directed the Department to take appppropriate corrective action in regard to certain specified Medi-Cal reimbursement rates paid to providers of outpatient services. The Court then remanded the matter to

defendant for further proceedings consistent with the Court's Order.

Pursuant to the remand, the Department conducted a review of outpatient rates. The review culminated in September 1993 in a 53-page study entitled Consideration of Efficiency, Economy, Quality of Acre [sic] and Access With Respect to Changes in Medi-Cal Reimbursement for Hospital Outpatient Services. 1 AR. The rate study reference included over seven hundred pages of supporting material. 2 AR 1-738.

On December 16, 1993, the Department held a public hearing in Sacramento with regard to those rates. Public comments and voluminous materials were received from various sources, including plaintiffs. 3 AR 71-2159. The Department reviewed the materials and generated a summary document, entitled "Addendum to Report, Rate Study by the Department of Health Services." 3 AR 8-46.

On April 15, 1994 the Department determined that there was no basis for alteration of the rates. The Department readopted the reimbursement levels of hospital outpatient services as currently set forth in Medi-Cal regulations. 3 AR 1.

Plaintiffs, dissatisfied about the result of the remand, have now returned to this Court. The Court is left with the same question it confronted in Orthopaedic I. Are the rates valid under federal law?

II. Statutory Analysis

A. Plaintiffs May State a Claim Under 42 U.S.C. § 1983

Defendant contends that plaintiffs do not have standing to sue the State under § 1396a(a)(30)(A) pursuant to the civil rights laws. In Orthopaedic I, the Court held that hospitals could sue under § 1983 pursuant to Wilder v. Virginia Hospital Assoc., 110 S. Ct. 2510 (1990). Wilder held that the Boren Amendment (§ 1396a(a)(13)(A) did create a private cause of action for providers to sue under the Civil Rights laws. Id. at 2525. This Court used the Wilder test and held that § 1396a(a)(30)(A) created a private cause of action for hospitals as well. After the decision in Orthopaedic I, the Supreme Court held that there was no private cause of action in a similar statute[3] because, in essence, the statute was so vague that it was beyond the competence of the judiciary to enforce. Suter v. Artist M., 112 S. Ct. 1360 (1992). See also Sobky v. Smoley, 855 F. Supp. 1123, 1133 (E.D. Cal. 1994) (interpreting Suter).

If Suter were still good law, then the Court would be forced to seriously reconsider its decision in Orthopaedic I that § 1396a(a)(30)(A) is judicialy enforceable. However, Congress passed Pub. Law 103-432 on October 31, 1994.[4] This law states:

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3. Section 671(a)(15) of the Adoption Assistance and Child Welfare Act of 1980.

4. The statute explicitly applies to actions pending at the time of enactment.

> In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M. [] but not applied in prior Supreme Court decisions respecting such enforceability: *Provided, however*, That this section is not intended to alter the holding in Suter v. Artist M. that section 471(a)(15) of the Act is not enforceable in a private right of action.

Pub. L. No. 103-432, § 211 (October 31, 1994).

Based on the plain language of this statute and its legislative history, the Court holds that Suter no longer binds the Court for the purposes of determining whether § 1396(a)(30)(A) is judicially enforceable.

First, under the plain language of the statute, courts are supposedc to go back to the three part test applied before Suter. This seems to preclude Suter's one prong ambiguity test.

Second, the legislative history of the act seems to indicate that the intent of the statute was to overturn Suter's analysis while keeping its holding.[5] That is,

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5. See, e.g., Report of the Committee on the Budget, House of Representatives, to accompany H.R. 2264, § 13224 ("The intent of the provision is to assure that individuals who have been injured by a State's failure to

Congress liked Suter's holding that section 671(a)(15) of the Adoption Assistance and Child Welfare Act of 1980 was not judicially enforceable. But Congress did not like Suter's methodology. Congress clearly desired that District Courts return to the Wilder test.

Defendant argues that despite § 211, Suter remains viable, at least to the extent that it informs courts about when a statute is overly vague. The Court disagrees. If defendant were right, then § 211 would have no meaning. Courts would be forced to cite to Suter, and Congress' intent would not be realized.

Accordingly, the Court disregards Suter and reaffirms its holding in Orthopaedic I that § 1396a(a)(30)(A) is judicially enforceable. Plaintiffs have a private cause of action under the civil rights laws to enforce § 1396a(a)(30)(A).

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comply with the Federal mandates of the State plan titles of the Social Security Act are able to seek redress in the federal courts to the extent they were able to prior to the decision in Sutter v. Artist M., while also making clear that there is no intent to overturn or reject the determination in Suter that the reasonable efforts clause of title IV-E does not provide a basis for a private right of action.") (Exhibit 3 to the Defendant's Further Briefing re: Motion for Summary Judgment).

B. Statutory Interpretation

1. Background

Plaintiffs and the Department fundamentally disagree about the interpretation of § 1396a(a)(30)(A). According to the Department, § 1396a(a)(30)(A) allows payments of any amount, provided Medi-Cal beneficiaries have access to services of adequate quality. See, e.g., 1 AR 15, 3 AR 12.

Plaintiffs argue that the statute, its legislative history, and relevant caselaw all reflect that the efficiency, economy, and quality of care requirement imposes a minimum payment level for hospitals, and requires that rates be sufficient to permit an efficiently and economically operated hospital to furnish quality care solely in return for such rates, without considering other factors. In other words, they argue, the rates must ensure that efficiently and economically operated hospitals are reimbursed the costs they must incur to furnish quality care.

2. Separate Standard for Hospitals

The Medicaid Act requires that Medicaid programs cover hospital outpatient services as a distinct item. §§ 1396a(a)(10)(A), 1396d(a)(1), (2). From this, plaintiffs argue that hospital outpatient rates must comply separately with the Medicaid Act, including § 1396a(a)(30)(A), and thus must be consistent with efficiency, economy, and quality of care, and ensure equal access, irrespective of the rates paid to non-hospital providers.

Plaintiffs' argument is belied by the plain language of statute read as a whole. Sections 1396a(a)(10)(A) and 1396d(a)(1), (2) deal with access. Section 1396a(a)(10)(A) states that a state plan must provide "for making medical

assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) . . . ." Section 1396d(a) simply enumerates certain types of medical services, including (1) inpatient hospital services; (2) outpatient hospital services; (3) laboratory and x-ray services; (4) nursing facility services; (5) physicians services; (17) nurse-midwife services; and (21) pediatric nurse practitioner or certified family nurse practitioner services.

Neither section explains which requirements the payments for each type of service must comply with. Rather, they generally explain what services Medi-Cal beneficiaries must be able to obtain.

Section § 1396a(a)(A), on the other hand, is a rate-setting statute. The section requires each state Medicaid plan

> to provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

§ 1396a(a)(30)(A) (emphasis added).

The statute refers to "care and services" and "payments" generally. Specifically in regard to the access portion of the section, the statute requires that "payments" be "sufficient to enlist enough providers so that care and

services are available . . . to the extent that such care and services are available to the general population . . . ." The statute seems to contemplate that as long as the "payments" for "care and services" meet the three requirements of the section they will be adequate. No statutory language indicates that the payments for each different type of service (i.e. hospital outpatient services, physician services, etc.) has to meet the § 1396(a)(30)(A) requirements individually.

The important point is whether the beneficiaries have access to outpatient services. Under § 1396(a)(3)(A) it is irrelevant whether the beneficiaries get outpatient services at hospitals or physicians' offices.

Plaintiffs further argue that if payment rates for hospital outpatient services need not comply separately with § 1396(a)(30)(A), state Medicaid programs could evade the requirement that hospital outpatient services be covered by establishing rates for such services so low that they would not be available. See DeGregoria v. O'Bannon, 500 F. Supp. 541, 549 (E.D. Pa. 1980) ("[U]nless rates are set for each of the required services at a level which will offer a sufficient number of providers the opportunity to receive payments which will exceed their marginal cost . . . it would be possible for states to evade the federal requirement of providing all five categories of services by setting unreasonably low rates for certain disfavored services.").

This argument is flawed because states do have to ensure that beneficiaries have access to hospital outpatient services. Any rate that would substantially limit access to hospital outpatient services would be contrary to § 1396a(a)(30)(A). Thus, so long as beneficiaries have adequate access to hospital outpatient services, there is no need to require that the payments for such services

separately comply with the efficiency, economy, and quality of care criteria.

Furthermore, it would actually be inconsistent with the criteria of efficiency and economy to increase service-specific rates (e.g. the rate for a specific outpatient procedure) paid to hospitals solely because they have higher costs than other types of providers supplying the same service. States should have the right to set rates at the most efficient and economical level, so long as the beneficiaries have access to the services. To set payments at an efficient and economical level, states must have the flexibility to use innovative approaches, including providing incentives for one type of care over another. See House Budget Comm. Rep. No. 97-158, § 6321 (1981) ("Budget Committee Report"). Section 1396a(a)(30)(A) was not created to ensure that hospitals receive full reimbursement, but rather was intended to keep Medi-Cal costs down in general. See generally id.

Finally, a comparison between § 1396a(a)(30)(A) and the Boren Amendment (§ 1386a(a)(13)(A)) shows that hospital outpatient rates need not separately comply with the § 1396a(a)(30)(A) requirements. The Boren Amendment does base rate-setting on provider costs by explicitly requiring states to pay the costs incurred by efficiently and economically operated providers. The Boren Amendment, however, only applies to hospital inpatient services. The Boren Amendment shows that Congress knows how to make rate-setting standards that require payments to be in line with provider costs. Congress did not do so in regard to outpatient rates under § 1396(a)(30)(A) or any other section.

For the foregoing reasons, the Court holds that hospital outpatient rates need not separately comply with § 1396a(a)(30)(A).

3. Minimum Payment Standard

Even assuming that hospital outpatient rates must separately comply with § 1396a(a)(30)(A), there is no basis to plaintiffs' argument that the efficiency, economy and quality of care criteria require that payments be sufficient such that they reimburse an efficiently run hospital for its costs.

Plaintiffs' argument is fairly simple. Section 1396a(a)(30)(A) requires that payments be "consistent" with "quality of care." Plaintiffs argue that if hospitals are not reimbursed for their costs, hospitals will be unable to provide quality care. Thus, they say, payments below costs are not consistent with quality of care.

The Court agrees with plaintiffs' proposition that payments be consistent with quality of care. The statute says so. If California's rates were insufficient for quality of care, then they would be contrary to the statute. But that does not mean that hospitals must be fully reimbursed for their costs. Their jump in logic does not follow.

The key issue in regard to whether there is a minimum payment is the third part of the section, the access portion. Section 1396a(a)(30)(A) requires that payments be consistent with efficiency, economy and quality of care, and be "sufficient to enlist enough providers" so that there is access to services comparable to that available to the general population in the geographic area. (Emphasis added).

This sufficient access requirement negates any inference that the quality of care standard requires hospitals to be fully reimbursed for their costs. Payments do not have to be sufficient to reimburse hospitals for their costs, but need only be sufficient to ensure access.

Plaintiffs do not even contend that the payments are insufficient to ensure access under § 1396a(a)(30)(A). Accordingly, the plain language of the statute forecloses the conclusion that § 1396a(a)(30)(A) requires hospitals to be reimbursed for their costs.

This conclusion is bolstered by another section of § 1396a(a)(30)(A), the utilization control requirement. This requirement shows that Congress was more concerned about excessive payments than insufficient payments.

This conclusion is also bolstered by the legislative history of the statute. The statute was enacted as a cost-containment measure, and it originally imposed a payment ceiling that required that payments not be "in excess of reasonable charges consistent with efficiency, economy, and quality of care." In 1981, § 1396a(a)(30)(A) was amended to remove the language "in excess of reasonable charges."

The Budget Committee Report indicates that Congress had no intention of creating a minimum payment level. On the contrary, Congress was deeply concerned about escalating health care costs, particularly in hospitals. See Budget Committee Report at §§ 6321, 6327. If anything, Congress hoped that with flexibility costs might decrease.

According to the Budget Committee Report, the "reasonable charge" language was removed because of the "administrative burdens" that the reasonable charge limitation imposed on states. It was intended to provide states "with the flexibility to create incentives to improve the availability and utilization of physician services under Medicaid." The Committee further noted the removal of the reasonable charge limitation would not result in an

"increase in expenditures for physician services under Medicaid." Rather, the Committee indicated that it expected states to "improve the administration of their Medicaid programs and to try innovative approaches to physician payment rather than merely . . . raise physician fees above Medicare levels."

This legislative history indicates that Congress did not envision that hospitals would be fully reimbursed for their costs under § 1396a(a)(30)(A). Rather, payments must be sufficient to ensure quality of care and sufficient access. If those criteria are satisfied, it is irrelevant whether hospitals make or lose money treating Medi-Cal beneficiaries. The legislative history shows that states have the flexibility to disfavor expensive hospital outpatient rates. Combined with the plain language of the statute, the only possible conclusion is that the section does not require the rates to reimburse hospitals for their costs.

III. Review of the Administrative Process

A. Standard of Review

In Orthopaedic I, the Court set out in full the standard for review of an agency action. See Order filed October 6, 1992. The Court will not repeat the full discussion. To summarize, the Court must determine whether the Department considered all the relevant factors when it established the Medi-Cal rates at issue, and whether the facts found and relevant factors considered by the Department are rationally connected to the outpatient payment rates set.

B. Analysis

As a preliminary matter, the Court must dispose of one of plaintiffs' pervading themes. Plaintiffs argue that

the Department misunderstood the Court's Order in Orthopaedic I. They contend that the Department should have engaged in an entirely new rulemaking process and should have adopted new payment rates that would be consistent with efficiency, economy, and quality of care. The Court rejects plaintiffs' contention. The Court contemplated that the Department would consider the relevant factors in regard to the rates rather than engage in an entirely new rulemaking process. The law requires nothing more. If the Court is satisfied that the Department considered the relevant factors, and that the rates are rationally related to the factors, then it must defer to the Department and uphold the rates.

Therefore, the Court must now determine whether the department has adequately considered the relevant factors in setting hospital outpatient rates, keeping in mind the Court's conclusions regarding the scope of § 1396a(a)(30)(A).

1. The Department Considered All Relevant Factors

Unlike Orthopaedic I, plaintiffs cannot and do not contend that the Department completely failed to consider efficiency, economy, and quality of care. The Department clearly considered the three factors; as is reflected in the totality of the AR. Rather, plaintiffs argue that the Department failed to meaningfully consider various other critical factors in assessing whether the rates are consistent with efficiency, economy, and quality of care.

First, plaintiffs contend that the Department failed to adequately consider hospital costs. The Court agrees that the Department has not demonstrated that it considered hospital costs in regard to all of the rate changes. Nevertheless plaintiffs' contention is meritless.

Because the Court concluded that hospital rates need to separately comply with the three factors, and because § 1396a(a)(30)(A) does not require that hospitals be fully reimbursed for their costs, the Department had no need to consider hospital costs at all. Thus, the Department did not abuse its discretion even though it did not consider hospital costs with regard to some of the rates.

Second, plaintiffs contend that the Department failed to consider inflation. Because § 1396a(a)(30)(A) did not require the Department to consider hospital costs in general, the Department certainly was not required to consider inflation.

Third, plaintiffs argue that the Department failed to take into account the rates paid in competitive markets. Once again, this is an irrelevant consideration given that the Department need not have considered hospital costs.

Fourth, plaintiffs argue that the Department has not adequately considered Medicare payment rates. The Court does not understand this argument. Medicare rates cannot possibly be relevant to the question of whether Medi-Cal rates are consistent with efficiency, economy, and quality of care. Medicare rates, unlike Medicaid rates, are specifically tied to provider costs. Nothing in § 1396a(a)(30)(A) or any other section of the Medicaid Act indicates that Medicaid rates must be consistent with Medicare rates.

Fifth, plaintiffs contend that the Department has not adequately considered the impact of the rates on specific facilities. Given that the Department had no need to consider the impact of the rates on hospitals in general, it certainly was not required to consider the impact of the rates on specific facilities.

The Court concludes that plaintiffs cannot demonstrate that the Department failed to consider all relevant factors. The only remaining issue is whether the rates are rationally related to the factors of efficiency, economy and quality of care.

2. The AR establishes that the Rates are Rationally Related to the Relevant Factors

Plaintiffs' final argument is that the current Medi-Cal rate structure does not bear any relationship to efficiency, economy, and quality of care. Of course, the Court need not find that the rates actually are consistent with efficiency, economy, and quality of care in order to uphold the rates. Rather, the rates must only be rationally related to the factors. This is not a particularly demanding standard, and the AR amply demonstrates the rational relationship between each rate change and the relevant factors.

Plaintiffs challenge seven discrete rate-setting decisions made by the Department between 1985 and 1990.

a. Reimbursement Augmentation for Small and Rural Hospitals

Effective June 18, 1990, the Department adopted regulations providing adjustment to Medi-Cal payment rates for small and rural hospitals. Cal. Code Regs. tit. 22, § 51509(1). See also 1 AR 36-40.

Several efficiency and economy considerations justify the higher rates for small and rural hospitals. First, small and rural hospitals have higher fixed costs than larger hospitals. Thus, rates that do not compensate for fixed costs would be more likely to discourage such

hospitals from providing Medi-Cal services. This, in turn, could lead to loss of emergency health care for Medi-Cal beneficiaries in rural areas, which could create more serious medical problems causing greater long term costs for the Medi-Cal program. Moreover, if rural hospitals were not reimbursed at a higher rate, they would be more likely to fail. This could result in a lack of emergency health care for even non-Medi-Cal beneficiaries, which would lead to more serious health care problems, including severe disability. Consequently, some persons might become eligible for Medi-Cal, thereby increasing long term costs to the Medi-Cal program. Thus, the rates are rationally related to efficiency and economy.

There is no evidence in the AR to indicate a quality of care problem in small or rural hospitals. In fact,

> Plaintiffs admit that there is no evidence in the Administrative Record that the services provided to Medi-Cal beneficiaries are of a lower quality of care than services provided to the general population by these same providers and that the evidence in the Administrative Record does not establish a downward trend in the quality of care provided by California hospitals in general.

Plaintiffs' Response to Defendant's Statement of Uncontroverted Facts and Conclusions of Law, pp. 10-11. Plaintiffs claim that this has to do with reasons other than the payment rates. Nevertheless, the fact remains. There is no quality of care problem for Medi-Cal beneficiaries in California.

Accordingly, the Court finds that the rates are rationally related to efficiency, economy, and quality of care.

b. Reimbursement Augmentation for Outpatient Disproportionate Share Hospitals

Effective May 24, 1989, the Department revised the Medi-Cal regulations to provide a methodology for increasing the Medi-Cal payment rates for hospital outpatient services applicable to hospitals that serve a disproportionate share of Medi-Cal beneficiaries and other low income patients. Cal. Code Regs. tit. 22, § 51509(k). See also 1 AR 31-36.

Hospitals incur greater fixed costs than other providers of outpatient services. Hospitals that serve a low number of Medi-Cal beneficiaries have very little fixed costs associated with the Medi-Cal services. Hospitals that serve a high share of Medi-Cal beneficiaries, on the other hand, must allocate a higher portion of their fixed costs to their Medi-Cal services. Thus, in order to encourage hospitals to serve a higher proportion of Medi-Cal beneficiaries, the Department must reimburse disproportionate share hospitals at higher rates. Because of the higher fixed costs allocable to the Medi-Cal program incurred by disproportionate share hospitals, the higher Medi-Cal rates for disproportionate share hospitals are rationally related to efficiency and economy.

There is no evidence of a quality of care problem in disproportionate share hospitals. Furthermore, the higher rates should encourage, not discourage, higher quality of care. Thus, the disproportionate share rates are rationally related to quality of care.

c. Non-Cesarean Section Obstetrical Services Rate-Setting

Effective December 9, 1988, the Department increased payment rates for non-cesarean section obstetrical services performed by physicians by 18%. Cal.code Regs. tit. 22, § 59400-30. See also 1 AR 24-28. The Department raised the rates, among other reasons, to provide adequate access to these services for Medi-Cal beneficiaries, to prevent children's health care problems, and to avoid more costly Medi-cal expenditures on medical problems that can occur when prenatal services are not received.

The AR demonstrates that this decision was well supported by efficiency and economy considerations. The Department noted that an increasing percentage of deliveries were being done by cesarean section. The Department believed that this was caused by the higher reimbursement rates for cesarean deliveries over non-cesarean deliveries. Because of the increased cost to the Medi-Cal program for paying for cesarean deliveries compared to non-cesarean deliveries, the Department raised the rates for non-cesarean deliveries. This rate change would serve to discourage physicians from performing cesarean deliveries, and thus would save the state money. Thus, the rate change was rationally related to efficiency and economy. Finally, as with the other rate increases, this rate-setting should not have a detrimental effect of quality of care. In sum, the rate changes are rationally related to efficiency, economy, and quality of care.

d. Delivery Services Rate-Setting

Effective January 19, 1990, the Department equalized the Medi-Cal payment rates for cesarean section

and non-cesarean section care and delivery services by lowering the rates for cesarean section deliveries. Cal. Code Regs. tit. 22, § 51503, 59400-30. See also 1 AR 28-30. Like the decision to increase the rates for non-cesarean section obstetrical services, this rate change is rationally related to efficiency and economy. The decrease in payments for cesarean section deliveries should discourage physicians from performing cesarean deliveries, which are more expensive than non-cesarean deliveries. Additionally, there is no indication in the AR that this decision negatively impacted the quality of care received by Medi-Cal beneficiaries. Accordingly, the Court finds that the rate change is rationally related to efficiency, economy, and quality of care.

e. Maternity, Children and X-Ray Services Rate-Setting

Effective August 5, 1988, the payment rates for physician maternity services were increased by 16%, the rates for physician office exams of children were increased by 10%, and the rates for portable x-ray transportation services were increased by 50%.

In Orthopaedic I, the court concluded that the Department adequately considered efficiency, economy and quality of care in regard to this rate-setting. Any attempt to challenge these affirmed rates is barred by res judicata.

f. Obstetrical Services Rate-Setting

Effective August 7, 1986, Medi-Cal payment rates for obstetrical services were increased by 26.5%. Cal. Code Regs. tit. 22, § 51503(b). See Also 1 AR 21-23. The immediate goal of this rate change was to increase the number of maternity care providers participating in the

Medi-Cal program in order to provide greater access for Medi-Cal beneficiaries. This rate change is rationally related to efficiency and economy. The higher payments for perinatal care should reduce the much greater potential expenditures that could be incurred in paying for life-long medical problems that might be prevented if Medi-Cal eligible mothers had greater access to perinatal and postnatal care services. Because the increase in payments could result in lower future medical payments, the change is rationally related to efficiency and economy.

Furthermore, because it was a rate increase the change should not result in a decrease in the quality of care received by Medi-Cal beneficiaries; thus the rate increase is rationally related to quality of care.

g. General Rate Setting

Effective August 1, 1985, the Department revised a broad spectrum of Medi-Cal rates so as to provide in effect for a 4% discretionary cost of living adjustment for Medi-Cal providers whose rates had not been reduced in a rate reduction that had occurred in 1982.[6] See 1 AR 19-21. The Department increased these rates in order to increase access for Medi-Cal beneficiaries. In the absence of a quality of care or access problem, it would have been contrary to efficiency and economy to have increased the rates any higher. As there is no evidence of either a quality of care or access problem, the Court concludes that the rate change is rationally related to efficiency, economy, and quality of care.

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6. These changes were promulgated in Cal. Code Regs., tit. 22, §§ 51503(b), (f), (g), (j), 51505.3(g), 51507(c), 51507.1(c), 51507.2, 51509(g)(2), 51513(d), 51529(a)(4)(E), (b), (c), 51531(b)(2).

C. Conclusion

The Court concludes that the Department considered all relevant factors and that the rates are rationally related to the factors. Accordingly, the decisions of the department were not arbitrary and capricious.

IV. Conclusion

In essence, plaintiffs' lawsuit is an attempt to force California to pay rates at a level that they are not required to satisfy under federal law. The Court must affirm the challenged rates based on the Social Security Act and the AR. If plaintiffs wish to receive higher payments, they should either lobby Congress to change the law, lobby the State to change the rates, or stop taking Medi-Cal beneficiaries. The Court DENIES plaintiffs' Motion for Partial Summary Judgment.

Although this motion for summary judgment was filed by plaintiffs, there is no reason for the Court to refrain from entering summary judgment for defendant. There are no facts in dispute that would warrant a trial. Both parties have submitted Statements of Uncontroverted Facts, and both parties have attempted to controvert the purportedly uncontroverted facts. However, all of the controverted "facts" are actually issues of law. They all revolve around interpretation of the AR. With no issues of fact or even inferences that need to be tried, the case must be disposed of by way of summary judgment. Rather than force defendant to file a separate motion for summary judgment, the court sua sponte GRANTS summary judgment for defendant in both cases CV 94-4764 SVW (JRx) and CV 94-4825 SVW (JRx).

The Court further DENIES defendant's Motion to Strike.

IT IS SO ORDERED.

DATED: 3/21/95

/s/ STEPHEN V. WILSON
STEPHEN V. WILSON
UNITED STATES DISTRICT JUDGE

APPENDIX C

FILED
MAR 27 1997
CATHY A. CATTERSON, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ORTHOPAEDIC HOSPITAL AND THE CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS,
Plaintiffs-Appellants,

v.

KIMBERLY BELSHE, THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA,
Defendant-Appellee.

No. 95-55607

D.C. Nos.
CV-94-4764 SVW (JRx)
CV-94-4825 SVW (JRx)

ORDER

Before: FLETCHER AND TASHIMA, Circuit Judges, and RESTANI,* Judge, U.S. Court of International Trade

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* Honorable Jane A. Restani, United States Court of International Trade, sitting by designation.

The panel as constituted in the above case has voted to deny the petition for rehearing. Judges Fletcher and Tashima have voted to reject the suggestion for rehearing en banc and Judge Restani has so recommended.

This full court has been advised of the suggestion for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35(b).

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

APPENDIX D

FEDERAL STATUTES

42 U.S.C. § 1396a provides, in pertinent part: "State plans for medical assistance

> "(a) Contents. A State plan for medical assistance must--
>
> * * *
>
> "(30)(A) provide for such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4) [42 U.S.C. § 1396b(i)(4)]) as may be necessary to safeguard against unnecessary utilization of care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . ."

42 U.S.C. § 1396a(a)(13) ("The Boren Amendment") provides in relevant part: "A State plan for medical assistance must . . . provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the state . . .) which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities

in order to provide care and services in conformity with applicable State and Federal laws. . ."

42 U.S.C. § 1983 provides that: "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

FEDERAL REGULATIONS

Title 42 Code of Federal Regulations (Oct. 1, 1996 ed.)

Subpart F-Payment Methods for Other Institutional and Non-Institutional Services

SOURCE: 43 FR 45353, Sept. 29, 1978, unless otherwise noted. Redesignated at 46 FR 47973. Sept. 30, 1981. Redesignated at 58 FR 6095, Jan. 26, 1993.

§447.300 Basis and purpose.

In this subpart, §§447.302 through 447.334 and 447.361 implement section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy and quality of care. Section 447.371 implements section 1902(a)(13)(F) of the Act, which requires that the State plan provide for payment for rural health clinic services in accordance with regulations prescribed by the Secretary.
[46 FR 48560, Oct., 1, 1981, as amended at 61 FR 38398, July 24, 1996]

* * *

§447.302 State plan requirements.

A State plan must provide that the requirements of this subpart are met.

[46 FR 48560, Oct. 1, 1981]

§447.304 Adherence to upper limits; FFP.

(a) The Medicaid agency must not pay more than the upper limits described in this subpart.

(b) In the case of payments made under the plan for deductibles and co-insurance payable on an assigned Medicare claim for noninstitutional services, those payments may be made only up to the reasonable charge under Medicare.

(c) FFP is available in expenditures for payments for services that do not exceed the upper limits.

NOTE: The Secretary may waive any limitation on reimbursement imposed by Subpart D of this part for experiments conducted under section 402 of Pub. L. 90-428, Incentives for Economy Experimentation, as amended by section 222(b) of Pub. L. 92-603, and under section 222(a) of Pub. L. 92-603.

[46 FR 48560, Oct. 1, 1981; 46 FR 54744, Nov. 4, 1981]

OUTPATIENT HOSPITAL AND CLINIC SERVICES

§447.321 Outpatient hospital services and clinic services: Upper limits of payment.

(a) *General Rule.* FFP is not available for any payment that exceeds the amount that would be payable to providers under comparable circumstances under Medicare.

(b) *Application of the rule.* Payments by an agency for outpatient hospital services may not exceed the total payments received by all providers from beneficiaries and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare.

[52 FR 28148, July 28, 1987]

OTHER INPATIENT AND OUTPATIENT FACILITIES

§447.325 Other inpatient and outpatient facility services: Upper limits of payment.

The agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

DRUGS

§447.331 Drugs: Aggregate upper limits of payment.

(a) *Multiple source drugs.* Except for brand name drugs that are certified in accordance with paragraph (c) of this section, the agency payment for multiple source drugs must not exceed, the amount that would result from the application of the specific limits established in accordance with §447.332. If a specific limit has not been established under §447.332, then the rule for "other drugs" set forth in paragraph (b) applies.

(b) *Other drugs.* The agency payments for brand name drugs certified in accordance with paragraph (c) of this section and drugs other than multiple source drugs for which a specific limit has been established under §447.332 must not exceed in the aggregate, payment levels that the agency has determined by applying the lower of the --

(1) Estimated acquisition costs plus reasonable dispensing fees established by the agency; or
(2) Providers' usual and customary charges to the general public.

(c) *Certification of brand name drugs.*

(1) The upper limit for payment for multiple source drugs for which a specific limit has been established under §447.332 does not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient.
(2) The agency must decide what certification form and procedure are used.
(3) A checkoff box on a form is not acceptable but a notation like "brand necessary" is allowable.
(4) The agency may allow providers to keep the certification forms if the forms will be available for inspection by the agency or HHS.

[52 FR 28657, July 31, 1987]

§447.332 Upper limits for multiple source drugs.

(a) Establishment and issuance of a listing. (1) HCFA will establish listings that identify and set upper limits for multiple source drugs that meet the following requirements:

(i) All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the most

current edition of their publication, *Approved Drug Products with Therapeutic Equivalence Evaluations* (including supplements or in successor publications).

(ii) At least three suppliers list the drug (which has been classified by the FDA as category "A" in its publication, *Approved Drug Products with Therapeutic Equivalence Evaluations* including supplements or in successor publications) based on all listings contained in current editions (or updates) of published compendia of cost information for drugs available for sale nationally.

(2) HCFA publishes the list of multiple source drugs for which upper limits have been established and any revisions to the list in Medicaid program instructions.

(3) HCFA will identify the sources used in compiling these lists.

(b) *Specific upper limits.* The agency's payments for multiple source drugs identified and listed in accordance with paragraph (a) of this section must not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee established by the agency plus an amount established by HCFA that is equal to 150 percent of the published price for the least costly therapeutic equivalent (using all available national compendia) that can be purchased by pharmacists in quantities of 100 tablets or capsules (or, if the drug is not commonly available in quantities of 100, the package size commonly listed) or, in the case of liquids, the commonly listed size.

[52 FR 28658, July 31, 1987]

§447.333 State plan requirements, findings and assurances.

(a) *State plan.* The State plan must describe comprehensively the agency's payment methodology for prescription drugs.

(b) *Findings and assurances.* Upon proposing significant State plan changes in payments for prescription drugs, and at least annually for multiple source drugs and triennially for all other drugs, the agency must make the following findings and assurances:

(1) *Findings.* The agency must make the following separate and distinct findings:

(i) In the aggregate, its Medicaid expenditures for multiple source drugs, identified and listed in accordance with §447.332(a) of this subpart, are in accordance with the upper limits specified in §447.332(b) of this subpart; and

(ii) In the aggregate, its Medicaid expenditures for all other drugs are in accordance with §447.331 of this subpart.

(2) *Assurances.* The agency must make assurances satisfactory to HCFA that the requirements set forth in §§447.331 and 447.332 concerning upper limits and in paragraph (b)(1) of this section concerning agency findings are met.

(c) *Recordkeeping.* The agency must maintain and make available to HCFA, upon request, data, mathematical or statistical computations, comparisons, and

any other pertinent records to support its findings are assurances.

[52 FR 28658, July 31, 1987]

§447.334 Upper limits for drugs furnished as part of services.

The upper limits for payment for prescribed drugs in this subpart also apply to payment for drugs provided as part of skilled nursing facility services and intermediate care facility services and under prepaid capitation arrangements.

§447.342 [Reserved]

PREPAID CAPITATION PLAINS

§447.361 Upper limits of payment:

Risk contract.

Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing those same services on a fee-for-service basis, to an actuarially equivalent nonenrolled population group.

[48 FR 54025, Nov. 30, 1983]

APPENDIX E

DECLARATION OF JAMES N. TAYLOR

[IN SUPPORT OF APPELLEE'S MOTION FOR STAY OF MANDATE PENDING PETITION FOR CERTIORARI]

I, JAMES N. TAYLOR, declare and state as follows:

1. The following matters stated in this declaration are true of my personal knowledge. If called as a witness, I would truthfully and competently testify consistent with the following:

2. I am the Chief of the Provider Rate Section of the Rate Development Branch of the California Department of Health Services (Department). I have worked for the Rate Development Branch since 1973. During that time, I have held a variety of managerial positions within the Rate Development Branch, including Branch Chief. In my current position, I supervise the establishment of Medi-Cal reimbursement rates for various types of outpatient services, including hospital outpatient services, physician services, pharmacy dispensing fees, durable medical equipment, and medical supplies. I am familiar with the recent decision of the United States Court of Appeals for the Ninth Circuit in Orthopaedic Hospital, et al. v. Belshé. I have held my current supervisory position throughout the various phases of the Orthopaedic litigation since 1990.

3. As I understand it, the Court of Appeals decision in the Orthopaedic case interprets title 42, United States Code section 1396a(a)(30) as requiring the Department to rely on cost studies and set payment rates to hospitals for outpatient services "that bear a reasonable relationship to efficient and economical hospitals' costs of

providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs."

4. The payment standard established by the Court of Appeals in the Orthopaedic case is very similar to the substantive federal payment standard contained in the Boren Amendment. The Boren Amendment is only applicable to the inpatient services (e.g., hospital inpatient services, nursing facility services) and requires the Department to set rates at a level that is "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with" applicable laws and "quality and safety standards." While it is similar to the Boren Amendment, it is not clear that the payment standard adopted by the Court of Appeals is identical to the Boren Amendment payment standard. For example, setting rates that "bear a reasonable relationship" to efficient and economic provider costs may not necessitate rates that "meet the costs" of such providers. Efficient and economic costs under section 1396(a)(30)(A) may also have a different meaning than "costs that must be incurred by efficiently and economically operated facilities" under the Boren Amendment.

5. There are thousands of Medi-Cal covered services, supplies, and items that are not subject to the Boren Amendment. Historically, the Department has established rates for these services by making sure there is adequate provider participation at the rates being paid so that there will be adequate access for beneficiaries. If there is an indication of an access problem, the Department has historically evaluated whether the problem was a result of low rates. This could involve a comparison of how the existing rates compared to typical provider charges for the services in question. The Department has data concerning typical provider charges

through the claims processing system. The Court of Appeals decision appears to require the Department to evaluate the adequacy of the rates for thousands of different services, supplies, and items based on a comparison to provider costs even if there is no access problem at the existing rates.

6. If the Department is mandated to set hospital outpatient rates pursuant to the payment standard set forth by the Court of Appeals in the Orthopaedic decision, it will create tremendous administrative and fiscal problems for the State. There will be difficult and time-consuming data collection tasks involved in setting outpatient rates pursuant to the new payment standard adopted by the Court of Appeals. There will also be difficult and time-consuming tasks involved in evaluating the data gathered and making decisions about what rates to pay for thousands of different hospital outpatient services. These difficulties are discussed in more detail in paragraphs 7 through 24 below. Depending upon how certain aspects of the Court of Appeals' decision are interpreted by the courts, the fiscal impact of implementing the new payment standard could vary from **millions to billions of dollars**, as discussed in paragraph[s] 25-26 below. Finally, the Court of Appeals' decision could trigger lawsuits from other outpatient providers, with similar administrative and fiscal consequences for the State, as discussed in paragraph 27.

7. The Boren Amendment is applicable to payment rates for only hospital inpatient services and long term care services such as skilled nursing facility services. Daily rates are established based on estimates of daily costs incurred for providing hospital inpatient services and long term care services. The daily rate compensates the provider for all services, supplies, or items encompassed within the rate. On the other hand, rates for outpatient

services such as hospital outpatient services are paid on a service by service basis. Unless the Department establishes a completely new method of paying for hospital outpatient services (e.g., contract basis, rate per visit), a separate rate will need to be set pursuant to the new payment standard for thousands of different outpatient services. That presents the first administrative difficulty in complying with the Court of Appeals decision. As discussed in paragraph 24, even if the Department changed its method of paying for hospital outpatient services, most of the administrative difficulties outlined in this declaration would still be applicable as well as some new ones.

8. Title 22 California Code of Regulations (CCR), section 51113 defines hospital outpatient services as "diagnostic, preventive, or therapeutic services furnished on an outpatient basis on the premises of a hospital." Title 22 CCR, section 51331 identifies 20 categories of health care services as hospital outpatient services when provided on an outpatient basis on hospital premises. Those services include physician services, optometric services, psychology services, podiatric services, physical therapy, occupational therapy, speech therapy, audiology services, speech pathology, acupuncture, dental services, laboratory and X-ray, blood and blood derivatives, chronic hemodialysis, hearing aids, prosthetic and orthotic appliances, durable medical equipment, medical supplies, and prescribed drugs. Title 22 CCR section 51509 indicates that all of these services are reimbursable as hospital outpatient services when provided on an outpatient basis on hospital premises.

9. According to the Physicians' Current Procedural Terminology, published by the American Medical Association in 1996, there are 7,000 to 8,000 physician procedures, which if performed on an outpatient

basis on hospital premises, would be a hospital outpatient service. There are also variations or components of physician procedures, which result in different services that can be billed under a single physician procedure. For example, there may be a single procedure code for a particular radiology procedure. However, in providing that procedure, the hospital will bill separately for the service of the technician and the physician. Billing modifiers are used to describe separate services involved in performing a single procedure. Based on a review of Medi-Cal claims data for the period January 1996 through June 1996, there are at least 11,636 separate physician services (including procedure modifiers) that hospitals bill as hospital outpatient services to the Medi-Cal program.

10. In addition to physician services, there are thousands of other medical services, supplies, and items for which hospital outpatient rates would have to be established pursuant to the new payment standard adopted by the Court of Appeals. There are approximately 12 optometric services, 26 psychology services, 765 podiatric services, 22 physical therapy services, 11 occupational therapy services, 8 speech therapy services, 30 audiology services, 2 acupuncture services, 1539 laboratory and X-ray services, 26 chronic hemodialysis services, 23 hearing aid items, 1,167 prosthetic and orthotic appliances, 210 durable medical equipment items, 4,391 medical supplies, and thousands of drugs. Therefore, including drugs and physician services, there are at least 20,000 different medical services, supplies and items that fall within the definition of hospital outpatient services pursuant to title 22 California Code of Regulations sections 51113 and 51331. In its petition for rehearing, the Department estimated that there were approximately 8,000 hospital outpatient services. This estimate was too low because it did not take into account procedure modifiers and all of

the non-physician services, supplies, and items provided by hospital outpatient departments.

11. Setting payment rates for inpatient hospital and long term care services under the Boren Amendment is a complicated process. However, one advantage is that the Boren Amendment expressly addresses the important data gathering aspect of the rate setting process. The Boren Amendment requires inpatient providers to file uniform cost reports. Pursuant to that requirement, inpatient providers annually submit cost reports detailing their costs of providing inpatient services. These cost reports are used by Department staff to establish reimbursement rates that comply with the Boren Amendment. Other than the Boren Amendment, I am not aware of a federal Medicaid statute requiring outpatient providers to submit cost reports. With the exception of inpatient services pursuant to the Boren Amendment, rural health clinic and Federal-qualified health center services pursuant to title 42, USC, section 1396a(a)(13)(E), and home and community care pursuant to title 42, USC, section 1396a(a)(13)(F), I am not aware of any other federal law imposing a minimum payment standard based on provider costs. Consequently, for the vast majority of outpatient services, there are no established procedures, standards, and rules concerning the cost data needed to set rates pursuant to the payment standard adopted by the Court of Appeals.

12. Hospitals annually file cost reports, which are available for review by the Department. However, these cost reports do not contain the specific costs of providing each of the thousands of medical services, supplies, and items provided as hospital outpatient services. In the plaintiffs' reply to the Department's rehearing petition to the Court of Appeals, they suggested that by using hospital cost reports, the

Department could set rates for hospital outpatient services consistent with the standard adopted by the Court of Appeals. The plaintiffs said that from hospital cost reports, the Department could determine the ratio's [sic] of each hospital's costs to its charges for each type of outpatient service. The plaintiffs indicated that because the Department does maintain data on hospital charges, it could apply each hospital's cost/charge ratio to the hospital's usual charges to determine the cost for each service, supply, and item provided by the hospital.

13. The plaintiffs' suggested approach would still require a tremendous amount of time and effort to implement and it is not clear that it would lead to reliable cost estimates for each of at least 20,000 hospital outpatient services. The plaintiffs' suggested approach would be quite time consuming because the Department would have to review cost reports for approximately 600 hospitals that provide hospital outpatient services under the Medi-Cal program and determine cost to charge ratios from those reports. The Department would then have to review Medi-Cal claims data to determine the usual charge from each hospital for at least 20,000 different hospital outpatient services. The cost to charge ratios determined for all 600 hospitals would then have to be applied to the usual charges to determine an estimated cost for each hospital for each of at least 20,000 different hospital outpatient services. This could amount to at least **12 million different cost estimates** for all the hospital outpatient services provided by all participating hospitals.

14. In addition to the complexity of the plaintiffs' suggested approach, it would not necessarily result in reliable cost estimates for each hospital that could be used for the next step of determining an efficient and economic cost for each hospital outpatient service. The reason for that is that this cost reports only enable the

Department to determine aggregate cost to charge ratios for hospital outpatient services. A hospital is unlikely to have a cost to charge ratio that is identical for each of the thousands of hospital outpatient services it provides. Therefore, if the Department applied the aggregate cost to charge ratios available from hospital cost reports to the usual charges for thousands of different services for each hospital, the resulting cost estimates may not be sufficiently reliable. For example, if hospital cost to charge ratios for specific services are higher than the aggregate cost to charge ratios, hospitals may argue that the Department's cost estimates derived from applying a[n] aggregate cost to charge ratio are too low.

15. If it is determined that more precise estimates of provider costs than can be derived from currently available hospital cost reports are needed to set rates pursuant to the new payment standard, it may be necessary to establish new rules and standards for hospitals to report their costs of providing outpatient services. It might be necessary for the Department to adopt these rules and standards as regulations pursuant to the California Administrative Procedure Act (APA). The process of adopting regulations pursuant to the APA can take up to 9 months.

16. Even after standards are established for the type of data that will be used to determine the costs to hospitals of providing outpatient services, the process of gathering the data and setting rates based on the data will be a lengthy and complicated process because of the thousands of medical services, supplies, and items for which rates must be set. Even if the Department followed the plaintiffs' suggested approach of estimating costs, the result could be a cost estimate for each hospital for at least 20,000 different hospital outpatient services. The estimated cost of each hospital for at least 20,000 different

hospital outpatient services may have to be arrayed in some fashion in order to determine an efficient and economic cost for each service. The Department would have to decide whether to establish cost efficiency and economy based on a percentile (e.g., 25 percentile) of estimated costs for each service for all providers, an average of all provider costs for each service, or some other basis. If it decides on a percentile approach, it would have to decide what percentile of costs to use and whether the same percentile is appropriate for each of the thousands of hospital outpatient services. A different percentile might be necessary depending upon the specific service involved. If the Department decides on a[n] average cost approach, it would have to determine whether to use a simple average or a weighted average. A weighted average based on the volume that each hospital provides of a particular service might be more accurate but much more complicated.

17. After the Department has determined an efficient and economic cost for each of thousands of different hospital outpatient services, it must then determine a rate that bears a reasonable relationship to the efficient and economic cost for each service. At some point in the process of establishing rates in accordance with the standard adopted by the Court of Appeals, the Department will need to consider the criteria of access and quality of care. Such consideration might be necessary when the Department determines an efficient and economic cost for each service or when it determines what is a reasonable rate relative to the efficient and economic cost for each service. It might be necessary at both of those phases of the rate setting process. While the Department has statutory responsibility for licensing and periodically surveying quality of care in hospitals, there has seldom been a focus on evaluating quality of care on a service by service basis. The Department will need to

evaluate whether that is necessary under the standard adopted by the Court of Appeals, and if not, what information is necessary in order to take quality of care into account under the new payment standard.

18. The Court of Appeals has established a new payment standard that, to my knowledge, has never been applied in setting outpatient rates. I am not aware of any third party health care payer, including Medicare, private health insurance company, or any state Medicaid program, that sets its rates for outpatient services by determining what an efficient and economic cost is for such services. The Court of Appeals has given the Department a task, that to my knowledge, has never been done. The Medicare program's reasonable cost method of setting rates involves setting rates based on a determination of the reasonable costs of providing all services on an aggregate cost center basis. (i.e., the aggregate reasonable costs of providing all services in the laboratory cost center). Interim rates are paid for all services in a cost center based on the ratio of reasonable costs to provider charges for the cost center. This ratio is determined based on the Medicare program's audit of a cost report submitted by each hospital for a prior period. A hospital's interim rates are retroactively adjusted after an audit of the hospital's cost report for the year for which the interim rate was paid. The reasonable cost methodology involves the payment of different rates to each hospital. It does not involve the determination of an efficient and economic cost. Therefore, many Medicare rates, based on the reasonable cost standard, may not be consistent with efficiency and economy.

19. To summarize what has been said to this point, the Department will have to do the following if it is going to establish payment rates for at least 20,000 hospital outpatient services. First, it will have to gather data that

can reasonably be used to estimate costs of providing each of these services by about 600 different hospitals. Second, it will have to evaluate the data and estimate the hospital costs for each of these services. Third, it will have to determine what is an efficient and economic cost for each of these services. Fourth, it will have to determine what is a reasonable rate relative to the efficient and economic cost for each of these services. Fifth, it will have to gather and consider available access and quality of care data at some stage of the process.

20. In order to estimate how many Department staff might be needed to set hospital outpatient rates pursuant to the new payment standard, it is instructive to look at Medi-Cal rate setting for hospital inpatient services and long term care services pursuant to the Boren Amendment. There are four basic types of long term care services provided under the Medi-Cal program, nursing facility, subacute care, pediatric subacute, and intermediate care for the developmentally disabled. However, there are about 38 different rates established for these basic types of long term care services based on geographic area, bedsize, level of care, and whether the provider is a hospital based or freestanding facility. Daily rates are also established for hospital inpatient services, which vary for each hospital based on an audit of each hospital's daily costs of providing hospital inpatient services. In summary, the Department sets daily rates for hospital inpatient services and about 38 daily rates for various long term care services based on estimates of the daily costs of providing those services. The Department must now apply the payment standard adopted by the Court of Appeals in setting rates for at least 20,000 different hospital outpatient services.

21. Establishing reimbursement rates for inpatient services that comply with the Boren Amendment

is a complicated and time-consuming process that requires many professional staff persons. The Rate Development Branch has a professional staff of 8 that work full-time in conducting an annual rate study for establishing rates for long term care services. The Rate Development Branch also has a professional staff of 16 that work full time in reviewing hospital cost data for the purpose of setting rates for hospital inpatient services that comply with the Boren Amendment. In addition to the Rate Development Branch Staff involved in annually establishing long term care and hospital inpatient reimbursement rates, there are about 40 Department auditors that audit cost reports submitted by hospitals and long term care providers. Audited costs are used by the Rate Development Branch staff to establish the rates.

22. The Department does not currently have sufficient staff that can be devoted to the time-consuming process of gathering and evaluating data concerning the costs of at least 20,000 hospital outpatient services and making the other determinations necessary to establish rates in accordance with the payment standard adopted by the Court of Appeals. If it takes about sixty-four (64) full time staff to annually establish daily rates for hospital inpatient services and 38 daily rates for long term care services, it could take at least that many staff to establish rates for at least 20,000 hospital outpatient services based on the efficient and economic cost of those services. It could take the Department several years to gather the necessary cost data and conduct the evaluation necessary to establish payment rates for all hospital outpatient services pursuant to the new payment standard. If staff are taken away from current positions, it could compromise other important Department duties and responsibilities. Therefore, the Department may be forced to hire a very large number of new staff to implement the new payment standard with respect to hospital outpatient

rates. The Department could hire a private consultant to conduct some of the work required to set rates pursuant to the new payment standard. However, this could be at a multi-million dollar cost to the Department and a large number of additional staff would still be needed for cost auditing and other data gathering duties.

23. In summary, I estimate that the process of establishing hospital outpatient rates in accordance with the payment standard adopted by the Court of Appeals will take several years and potentially require the hiring of a staggering number of new staff (e.g., possibly at least 64). This estimate is based on several factors. It will take several months to develop a plan for implementing the decision, hire necessary staff, and/or possibly hire a private consultant. It could a year to gather the necessary cost data for at least 20,000 hospital outpatient services. The process of evaluating the data, making decisions related to efficiency and economy, and deciding on a reasonable standard of reimbursement for at least 20,000 hospital outpatient services could take at least a year. Finally, the Department would have to comply with the California APA in adopting new rates into regulation. As noted earlier, that process can take up to 9 months.

24. As noted previously, longstanding Medi-Cal practice has been to pay a separate rate for each outpatient service. At this point, I assume the Department would continue that policy. The Department could consider a different method of paying for hospital outpatient services, such as a per visit basis. Under that approach, a hospital would get paid a single rate for a outpatient visit regardless of the services provided during the visit. (e.g., hospital gets the same rate for treating someone with a cold as it does for performing a complicated outpatient surgery). Paying for outpatient services on a per visit basis would be a radical change, and

the Department would need several months to evaluate its appropriateness. The Department would have to evaluate the advantages and disadvantages, including the views of the provider community, and obtain necessary approval from upper management before making such a change. Many providers might object and a per visit method of paying could be subject potential abuses by providers. I am sure there are potential problems, which I have not yet thought of. Even if the Department were to make such a radical change in its method of paying providers, the administrative difficulties outlined above would still be applicable. The Department would still have to gather cost data, evaluate the data to establish standards of efficiency and economy, consider access and quality of care, and establish reasonable rates on a per visit basis that compensate as many at least 20,000 separate hospital outpatient services. In order to implement the new rates, the Department would have to completely re-program its current claims processing system which is now programmed to pay for the thousands of hospital outpatient services on a service by service basis. The necessary re-programming of the claims processing system could take many months at a significant monetary cost.

25. Depending upon how cost efficiency and economy is defined and what the standard is for a rate that "bears a reasonable relationship" to such cost, the most impact of implementing this decision could be **hundreds of millions** of dollars annually for just hospital outpatient services. Another problem if the Court of Appeals decision is not stayed is that the plaintiffs in the Orthopaedic case are likely to file a motion to the United States District court for interim relief pending the Department's review of its rates. In an earlier phase of the Orthopaedic litigation, they obtained a judgment in October 1992, that required the Department to re-evaluate its rates in accordance with the standard of "efficiency,

economy, and quality of care." That rate evaluation took the Department about 11 months and resulted in a 53 page rate study in September 1993. Prior to the completion of that study, the plaintiffs filed a motion for an order to require the Department to pay interim rates pending completion of the Department's study. The plaintiffs sought interim rates equal to the providers' usual and customary fees. The cost impact of paying hospital outpatient rates at that level was estimated to be $ 1 billion annually. The plaintiffs might file a similar motion if the Court of Appeals decision is not stayed.

26. There are also two pending state court lawsuits against the Department with respect to hospital outpatient rates. One lawsuit, San Bernardino County, et al. v. State of California was filed in 1990 on behalf of 8 counties that provide hospital outpatient services in county hospitals. The other lawsuit, Barlow Respiratory Hospital v. State of California, was filed in October 1992 and has been certified as a class action on behalf of all hospitals providing hospital outpatient services under the Medi-Cal program. Both cases have been consolidated. The San Bernardino lawsuit seeks retroactive relief back to 1985 and the Barlow Respiratory Hospital lawsuit seeks retroactive relief back to 1988. If the Court of Appeals decision is not stayed pending the Department's petition to the Supreme Court, the plaintiffs in these cases are likely to immediately press their claims for retroactive relief. The potential fiscal impact of paying retroactive relief in these cases could be billions of dollars.

27. If the Court of Appeals decision is not stayed, the administrative and fiscal impact on the Department could be further exacerbated by other outpatient provider lawsuits contending that the Department must now set all outpatient rates in accordance with the payment standard adopted by the

Court of Appeals. The plaintiffs indicated in their response to the Department's rehearing petition that the new payment standard would not necessarily apply to other outpatient services. I hope they are right, but that will not stop other outpatient providers who may want to file lawsuits. There are also at least **20,000** different non-hospital outpatient medical services, supplies, and items. In order to establish a separate rate for each of these pursuant to the standard adopted by the Court of Appeals, the Department would face all the administrative and fiscal problems stated above in setting rates for hospital outpatient services. Additional staff would have to be hired and potentially millions of more dollars would have to be paid to a private consultant to assist the Department in setting rates for these services, supplies, and items. Furthermore, the administrative difficulties could be even more difficult than setting rates for hospital outpatient services. Whereas there are hospital cost reports that potentially provide some useful aggregate cost data relative to hospital outpatient service, the Department does not have access to cost data for thousands of services, supplies, and items provided by all the other providers of outpatient services. While the Department has statutory responsibility for licensing and periodically inspecting quality of care provided by general acute hospitals, long term care facilities, and certain health care clinics (e.g., Health and Safety Code section 1201, 1204, 1204.1, 1228, 1250, 1254, and 1279), it has no similar statutory responsibility for licensing and inspection of other health care providers. Therefore, the Department may have difficulties obtaining necessary quality care information.

I declare under penalty of perjury that the foregoing is true and correct. Executed at Sacramento, California, on this 2nd day of April, 1997.

/s/ JAMES TAYLOR
JAMES N. TAYLOR